Alberta Health Services

Affix patient label within this box

# Posterior Spine Surgery Requirements
***(Rockyview General Hospital)***

Complete and provide to Surgical Booking **at least two (2) weeks prior to surgery.**

| Date of Surgery *(yyyy-Mon-dd)* | Requested by | Surgeon Name |
|---|---|---|
| Procedure | | |
| Operative Level | Position | |

Complete the appropriate categories below by checking boxes or providing additional information.

**Bone Replacement**

- ☐ Grafton 2.5cc
- ☐ Infuse Small
- ☐ Infuse Large
- ☐ Other _____

**OR Table/Positioning Equipment**

- ☐ Cloward Saddle RGH
- ☐ Jackson Spine Top RGH

**C-Arm**

- ☐ 1 Required

**Minimally Invasive - Posterior**

- ☐ Metrx II — Medtronic
- ☐ Longitude — Medtronic

**Open**

- ☐ CD Horizon Legacy — Medtronic

**Additional Comments, Instruments, Special Instructions**