RETOUR FORMULIER

RELATIEGEGEVENS

Contactpersoon: _____

Praktijknaam (relatienr.): _____

Adres: _____

Telefoon: _____

E-mail: _____

Datum: _____ Handtekening: _____

RETOUR INFORMATIE

Ordernummer(s) of factuurnummer(s) van de retour producten: _____

Retour reden (kruis aan):

- ☐ Omruil
- ☐ Retour i.v.m. geen osseointegratie van implantaat *(vul achterkant van formulier in)*
- ☐ Retour van defect product
- ☐ Retour van een verkeerd ontvangen bestelling (afwijking van maten)
- ☐ Overig: _____

Artikelnummer	Aantal	Omschrijving	Batch nr.

Invoer door Implanetic

Retour nr: _____

Ontvangst conditie: ☐ originele verpakking ☐ open verpakking ☐ gebruikt product

Acceptatie van retour: ☐ ja ☐ nee datum _____ handtekening _____

Ondernomen actie: _____

Retouradres: Implanetic. Jan Muschlaan 21A, 3584 GV Utrecht (Nederland)

2 RETURN FOR NOT OSSEOINTEGRATED IMPLANT

CLINICAL INFORMATION

Sex of patient ☐ M ☐ W Age:_____ Position of the implant _____

Date of insertion_____ Date of uncovering _____

Date of the examination_____ Date of implant removal _____

More implant surgery ? ☐ Y ☐ N If Yes, position and outcome _____

HEALTH OF THE PATIENT

Indicate any temporary negative aspects related to the period of the intervention

(inflammatory diseases, infection, flu, bronchitis, sinusitis, etc... • temporary use of particular medicines: blood thinners, immunosuppressive agents, chemotherapy etc... • stressful situations, drug or alcohol abuse, neurological or psychotic syndromes., etc...)

Indicate any ageneral negative aspects of the patient's health

(cachectic or overweight patient, diabetes, hyperthyroidism, bleeding diseases, uncontrolled arterial hypertension, bony disorders, hepatitis etc...)

Indicate any negative aspects of endoral situation of the patient

(cyst, granulomas, mucosal disorders, poor oral hygiene, radiation therapy to the jaw etc...)

Indicate any negative habits of the patient

(bruxism, smoke, alcohol etc...)

Indicate the peri-implant status when removing the implant

(granulation tissue, infection in act, infectious agents etc...)

SPECIFIC INFORMATION ABOUT THE SURGERY

Membrane, graft material and/or filling for the inclusion of the removed implant? ☐ Y ☐ N

If YES, Which ones? _____

How many surgeries have been performed with drills and taps to insert the not osseointegrated implant? _____

Indicate the number of turns and the percentage of torques used during the surgery _____

Cooling: ☐ Internal & external ☐ external ☐ uncooled

Tapping: ☐ Y ☐ N if YES ☐ manual ☐ mechanical Insertion: ☐ manual ☐ mechanical

Indicate the possible reason for the failure in osseointegration in your opinion

(poor bone quality, overheating of bone, infection, inadequate primary stability etc...)

Date_____ Signature _____

PLEASE, FILL OUT ALL THE SECTIONS OF THE FORM AND ATTACH THE SUPPORTING MATERIAL LISTED BELOW: THE DOCUMENT WILL BE RETURNED AFTER THE ANALYSIS: RADIOGRAPHIC INSPECTION AFTER THE IMPLANT INSERTION. NOTE: I-res Srl may make use of laboratory tests only after analyzing this questionnaire duly completed and the radiographic inspection. Dip the implant in glutaraldehyde (4%) or formalin (10%) immediately after the implant removal if it must be analyzed. Insert all in a sealed container and send to I-res Srl.

I-res Srl guarantees maximum protection of all data supplied which are electronically processed according to honesty principles, lawfulness and transparency for the protection of privacy and used to send marketing information about our items. The transmission of data is optional, but it is necessary for ensuring performance. In case data are not provided, it will not be possible to participate in the initiative. According to article 13 of law 675/96, every involved person can ask to consult, modify, cancel its data with a written request to owner I-res Srl. CONSENSUS: the provision of the e-mail address and fax number (entirely without obligation) you hereby consent the use of data for the purposes outlined above.