


Guarantee form

 As specified in paragraph 8 of the Thommen Medical Guarantee, all applicable data protection regulations must be complied with and all patient data must be anonymized. A patient ID number, which does not allow any conclusions to be drawn about patient data, must be used for each patient.

1. CUSTOMER INFORMATION

Attending physician's name and address (use capital letters or stamp)

Telephone

Country

Contact at the practice

2. PRODUCT INFORMATION (please list all Thommen Medical products involved)

| Art. no. | Lot no. | Placement Date (D/M/Y) | Removal Date (D/M/Y) | Region |
|----------|---------|------------------------|----------------------|--------|
| _____ | _____ | ____ / ____ / _____ | ____ / ____ / _____ | _____ |
| _____ | _____ | ____ / ____ / _____ | ____ / ____ / _____ | _____ |
| _____ | _____ | ____ / ____ / _____ | ____ / ____ / _____ | _____ |
| _____ | _____ | ____ / ____ / _____ | ____ / ____ / _____ | _____ |

Date of the event: _____ / _____ / _____

3. GENERAL PATIENT INFORMATION (complete this section only if returning implants)

Patient ID no. _____ Age: _____ Female Male

Medical Record

- | | | |
|--|---|--|
| <input type="checkbox"/> Radiation Tx-head/neck area | <input type="checkbox"/> Blood coagulation disorder | <input type="checkbox"/> Psychological disorder |
| <input type="checkbox"/> Bisphosphonate treatment | <input type="checkbox"/> Compromised immune resistance | <input type="checkbox"/> Drug or alcohol abuse |
| <input type="checkbox"/> Illness requiring steroids | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Xerostomia |
| <input type="checkbox"/> Chemotherapy around time of implant placement | <input type="checkbox"/> Uncontrolled endocrine illness | Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No |

Other local or systemic diseases which may be significant: _____

Allergies: _____ No significant findings

4. INFORMATION (complete this section only if returning implants)

Manual placement Mechanical insertion

Comments (use capital letters): _____

If implant was placed and removed the same day, was another implant successfully placed in the site during surgery? Yes No

At the time of surgery, were any of the following present:

- | | | | | | |
|--|---|---------------------------------|----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Periodontal disease | Bone quality | <input type="checkbox"/> Type I | <input type="checkbox"/> Type II | <input type="checkbox"/> Type III | <input type="checkbox"/> Type IV |
| <input type="checkbox"/> Diseased mucous membrane | Use thread tap? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| <input type="checkbox"/> Local infection/ subacute chronic osteitis | Was primary stability achieved? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| <input type="checkbox"/> Complication in site preparation | Did implant achieve osseointegration? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Whichever: _____ | Was the implant surface completely covered with bone? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |

Was augmentation performed at the time of surgery?

No Sinus Ridge

Material used: _____

Was GTR membrane used?

No Yes Resorbable Non-resorbable

Material used: _____

5. EVENT INFORMATION (complete this section only if returning implants)

Hygiene around implant Excellent Good Fair Poor

Were any of the following involved in the event?

- | | | |
|---|---|---|
| <input type="checkbox"/> Trauma/Accident | <input type="checkbox"/> Undersized implant bed | <input type="checkbox"/> Preceding/simultaneous bone augmentation |
| <input type="checkbox"/> Biomechanical overload | <input type="checkbox"/> Overheating of bone | <input type="checkbox"/> Bone resorption |
| <input type="checkbox"/> Bruxism | <input type="checkbox"/> Nerve encroachment | <input type="checkbox"/> Peri-Implantitis |
| <input type="checkbox"/> Implant fracture | <input type="checkbox"/> Sinus perforation | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Immediate implantation | <input type="checkbox"/> Inadequate bone quality/quantity | |

Other (please write in capital letters): _____

At the time of implant failure, there was (check all that apply):

- | | | | |
|--|-----------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Swelling | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Mobility |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Fistula | <input type="checkbox"/> Inflammation | Other: _____ |
| <input type="checkbox"/> Increased sensitivity | <input type="checkbox"/> Abscess | <input type="checkbox"/> Asymptomatic | |

Was the prosthesis fitted?

- Yes No

If yes, please complete section 6.

Please comment on why you think the implant failed/was removed (please write in capital letters):

6. PROSTHESIS INFORMATION (complete this section only if returning abutments and restorations)

- Model Insertion In use
- Type of restoration? Crown Bridge RPD: Upper Lower
Full: Upper Lower
- Date abutment was installed? _____ / _____ / _____ Date of abutment removal: _____ / _____ / _____
(D/M/Y) (D/M/Y)
- Was the MONO torque ratchet used? Yes No Unknown Torque applied: _____ Ncm
- Date of temporary restoration installation: _____ / _____ / _____ Date of final restoration installation: _____ / _____ / _____
(D/M/Y) (D/M/Y)
- Was a check-up performed? Yes No

Description of event (please write in capital letters):

7. INSTRUMENTS (complete this section only if returning instruments)

- Which drills were used: VECTOdrill steel VECTOdrill ceramic
- Other Whichever: _____
- Approximate number of uses (cutting instruments only): Initial use 2-5 x 6-10 x 10-20 x More than 20 x
- Type of cleaning method used: Manual Ultrasonic Thermodesinfection Other: _____
- Type of sterilization method used: Autoclave Dry heat Chemiclave

Short description of incident (please write in capital letters):

Please return questionnaire, autoclaved product and include X-rays (as appropriate) to your distribution partner.

Use a padded pouch to return items – failure to do so could result in items lost during shipment and void guarantee program.

Autoclave all products (do not clean) and label them as **sterile**.

Based on the Thommen Medical Guarantee Terms and Conditions, please consider replacing the above listed products.

Doctor's Signature: _____ Date: _____