


# 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/<br>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: \_\_\_\_\_