

Please return item(s) sterilized and packed separately!

# Complaint Form

**to be filled by selling location**

Selling Location/ DI Division: \_\_\_\_\_

Complaint ref. no. of Selling Location/ DI Division: \_\_\_\_\_ **Complaint no:** \_\_\_\_\_

**Customer/User** Customer ID \_\_\_\_\_

Name \_\_\_\_\_

Street \_\_\_\_\_

Address \_\_\_\_\_

Contact/ Phone \_\_\_\_\_

**or Practice Stamp**

## Failed product (Implant, Component, Tool, etc.)

Astra Tech Implant System    
  Ankylos    
  Frialit/ Xive    
  \_\_\_\_\_

Name \_\_\_\_\_ Catalog no. \_\_\_\_\_ Lot no. \_\_\_\_\_  unknown

Concomitant product: \_\_\_\_\_

## Event Date of Event \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

- No Primary Stability      Implant Loss      Fracture of Implant
- Other Surgical or Insertion Issue (please describe below)
- Abutment Fracture      Screw Fracture      Loosening      Fit Issue
- Tool Issue (please describe below)
- Other (please describe below)

### Additional Information/ Description

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>Position:</b>		8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16
	<b>R</b>																	
		32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
	<b>L</b>																	

**Patient** Identifier \_\_\_\_\_

**Oral Hygiene**  excellent  fair  poor

**Bone Quality**  I  II  III  IV

**Medical History**  Smoker  Diabetes  Bruxism

**Chewing/ Bite Habits** \_\_\_\_\_

**Others** \_\_\_\_\_

**Date of** Implant placement \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Immediate Impl. Placement  yes  no

Loss/ explantation \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Immediate Loading  yes  no

Prosthetic Restoration \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Type of abutment \_\_\_\_\_

**Time of Implant Loss/ Explantation**  Healing Period  Re-entry  Prior to Functional Loading  After Functional Loading

**Healing**  Subgingival  Transgingival

**Augmentation**  Preoperative  At Time of Implant Placement  None

Grafting Materials \_\_\_\_\_

**Implant Site Preparation**  Bone Condensing  Bone Expanding  Bone Spreading  
 Drilling  Thread Cutter Others \_\_\_\_\_

**Diagnostic Findings before Explantation**  Infection  Mobility  Osteolysis  
 Occlusal Overload  Progressive Bone Loss  Periimplantitis

**Prosthetic Treatment**  Cemented  Complete Denture  Only Implant supported  Removable Bridge  
 Fixed Bridge  Fixed Partial Denture  Removable Partial Denture  Screw Retained  
 Implant/ Tooth supported  Single Tooth

**Additional Comments** \_\_\_\_\_

Item enclosed  other attachments \_\_\_\_\_

Item will be sent subsequently \_\_\_\_\_

Item won't be returned because \_\_\_\_\_

**Date** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **Signature** \_\_\_\_\_