

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 _____

or Practice Stamp

Name _____

Street _____

Address _____

Contact/ Phone _____

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

Position:	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
	R															L
	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

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** _____