



Please Return item(s) **sterilized** and packed separately!

Dear Healthcare Provider,

Thank you for purchasing Alpha-Bio Tec. products, which are manufactured to the highest quality standards and comply with the strictest international requirements.

In order to return the product in an orderly procedure, please follow the instructions below:

- ① Complete this form comprehensively and attach the sterilized product to it. Any missing information will delay processing. All fields are mandatory, unless otherwise written.
- ② Please add radiographs before and after the event.

1. Distributor Information			
Distributor Name			
Distributor Address			
Distributor Country			
2. Practitioner Information			
Practitioner Name			
Practitioner Address			
Practitioner Phone Number			
3. Product Information			
Part Number			
Lot Number			
Description			
4. Case Details			
Occurrence of event:	<input type="checkbox"/> At Arrival	<input type="checkbox"/> During clinical procedure	<input type="checkbox"/> After clinical procedure
<b>Product Complaint Type:</b>			
<input type="checkbox"/> Failure to Osseo integrate	<input type="checkbox"/> Primary stability couldn't be achieved	<input type="checkbox"/> Loss of sterility (not used)	
<input type="checkbox"/> Fractured part	<input type="checkbox"/> Wrong Size Chosen	<input type="checkbox"/> Packaging (please attach package & specify)	
<input type="checkbox"/> Labeling (please specify)	<input type="checkbox"/> Deformation (please specify)		
<input type="checkbox"/> External trauma (e.g. car accident), please specify	<input type="checkbox"/> Surface defect (product), please specify		
<input type="checkbox"/> Other, please specify:			





5. Surgery Information			
Implantation Date	__/__/____		
Date of prosthetic attachment	__/__/____		
Date of implant removal	__/__/____		
Instruments/abutments failure date	__/__/____		
6. Patient Information			
Patient Indicator (not name, due to confidentiality)		<b>Sex:</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
Age	<20   20-50   50-70   >70		
Patient Profile	<input type="checkbox"/> Bruxer <input type="checkbox"/> Smoker <input type="checkbox"/> Diabetic <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Steroid therapy <input type="checkbox"/> Current/previous radiation therapy in the area <input type="checkbox"/> Other _____		
7. Patient Injury*			
Patient Injury*	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____	
Date of event (dd/mm/yyyy)	__/__/____		
Permanent damage	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____	
Pain and numbness	Was the implant removed due to pain?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Was the implant removed due to numbness?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Did the pain/numbness disappear after the implant was removed?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>*All unplanned surgical procedures are injuries and require an immediate report to your local ABT representative.</b>			

Thank you for your cooperation!

FOR INTERNAL  
USAGE ONLY

