straumann

GUARANTEE QUESTIONNAIRE

1. CUSTOMER INFORMATION

Clinician's Name:		**Acct No.**	**1_742099**
	H.A.Systems Ltd.	**Tel:**	972-3-6138777
Address:	4 HaTa'as St	**Country**	Israel
	Ramat Gan 5251246	**Reported by**	Joan Toll

2. PRODUCT INFORMATION (Please list all involved Straumann Products)

Article Number	Lot Number	Placement D/M/Y	Removal D/M/Y	Tooth No.

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

Patient ID:		**Age:**		**Male:**		**Female:**	

Medical Record

Diabetes Mellitus		**Compromised Immuno Resistance**	
Radiation Tx-head\neck		**Blood Coagulation disorder**	
Steroid Treatment		**Lymphatic Disorder**	
Chemotherapy –recent		**Endocrine Illness**	
Psychological disorder		**Allergies**	
Xerostamia		**Smoker**	
Drug\Alcohol Abuse		**No Significant Findings**	

4. SURGICAL INFORMATION (Complete this section only if returning implants)

Manual Insertion	**YES \ NO**	**Handpiece Adaptor**	**YES \ NO**	
If an implant was placed and removed the same day, was another implants successfully placed in the site the same day?				**YES \ NO**
If you experienced difficulty with inserting device/premounted transfer this occurred upon:			**Implant insertion into bone**	**Removal of the device from the implant**
			Removal of implant from the vial	**Other:**
At the time of surgery were any of the following present?			**Periodontal disease**	**Diseased mucus membrane**
			Local infection/subacute chronic osteitis	**Other:**

Bone Quality	**Type I**	**Type II**	**Type III**		**Type IV**
Was the site tapped?					
Holding key used?					
Was primary stability achieved?					
Did implant achieve osseointegration?					
Was the implant completely covered with bone?					
Was augmentation performed at the time of surgery?			**Sinus**	**Ridge**	**Material:**
Was GTR membrane used?		**YES** / **NO**	**Resorbable**	**Nonresorbable**	**Material:**

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?

Trauma\accident		**Infection**	
Biocmechanical overload		**Buxism**	
Immediate extraction site		**Inadequate bone quality\quantity**	
Adjacent to endodontic tooth		**Previous bone augmentation**	
Tongue (pressure)		**Nerve encroachment**	
Implant fracture		**Sinus perforation**	
Overheating of bone		**Bone resorption**	
Periimplantitis		**Other:**	

At the time of implant failure there was:			
pain	bleeding	swelling	numbness
mobility	fistula	asymptomatic	inflammation
hypersensitivity	Increased sensitivity	abscess	Other:
Was the prosthesis fitted?		NO	If YES, complete section 6
Please comment on why you think the implant failed/was removed:			

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

Project No.	Model		Insertion	In use
Type of Restoration:				
Crown	Bridge		RPD upper	RPD lower
Full upper	Full lower		Other:	
Date abutment installed	D/M/Y		Date abutment removal	D/M/Y
Torque Control Device used	YES	Ncm	NO	Unknown
Date of temporary restoration installation	D/M/Y		Date of final restoration installation	D/M/Y
Was the recall appointment schedule followed?			YES	NO
Description of Event:				

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

Approximate no of uses (cutting instruments only)	Initial use	2-5	6-10	10-15	more than 15
Type of cleaning method used	manual	ultrasonic	thermodisinfection	Other:	
Type of sterilization method used	autoclave		dry heat	chemiclave	
Short description of event:					

Autoclave all products and label them as sterile.

Include x-rays (as appropriate)

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

Dr's Signature _____ **Date:** _____

FOR INTERNAL USE ONLY					
☐ CSN	☐ PSO	☐ ASR	☐ RPC	☐ Info Incomplete	☐ Std/No

HA Systems ID No.	