This form must be filled with the maximum information and details about the patient, containing the signature and stamp of the professional. Failure to complete the form shall lead to the return of the product, with the transportation charges being responsibility of the dental professional.

The dentist must send one form for each patient/clinical case to be analyzed. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMATIONS ABOUT THE CLINICIAN**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Professional name: | | | | |  | | | | | | |
| Address: | | | |  | | | | | | | |
| No. |  | | | | | | | | | | |
| ZIP: | |  | | | | City: |  | | State: |  | |
| Country: | | | |  | | | | Telephone: | | |  |
| E-mail: | | |  | | | | | | | | |

**INFORMATIONS ABOUT PRODUCTS INVOLVED IN THE CLINICAL CASE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Product code | Product name | Batch No. | | | | Quantity |
|  |  | No |  | Yes, which? |  |  |
|  |  | No |  | Yes, which? |  |  |

The item could be bought in your name or in other person’s or clinic’s name?

|  |
| --- |
|  |

**Observations:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Do you want to receive the complaint analysis report? | | | Yes | | |  | | | No | |  | | |
| Do you want the same item as replacement? | Yes |  | | | No | | |  | | | | Which? | | |  | | |
| The replacement will be for the same address mentioned above? | | | | Yes | | |  | | | No | | |  | | | Which? |  |
|  | | | | | | | | | | | | | | | | | |

**DESCRIPTION OF EVENT**

|  |
| --- |
|  |
|  |
|  |
|  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SELECT THE PROBLEM** | | | | | | | | |
|  | Osseointegration failure | |  | Clamping |  | Unusable product |  | Implant removal |
|  | Non conform product | |  | Deformation |  | Swallowing/Aspiration |  | Death |
|  | Without primary stability | |  | Fracture |  | Manipulation |  | Allergy |
|  | Other |  | | | | | | |

**PATIENT’S INFORMATION**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient ID: |  | | | | | | | |
| Birth date: |  | Gender: | Female |  | Male |  | Weight |  |

*Obs.: Fill only if country legislation allows.*

Mark with X the region where the implant was placed:

 

Dental numbers



**8**

**11**

**7**

**12**

**6**

**13**

**5**

**14**

**1**

**18**

**16**

**28**

**15**

**27**

**14**

**26**

**12**

**24**

**11**

**23**

**1**

**18**

**10**

**22**

**22**

**13**

**25**

**9**

**21**

**4**

**15**

**3**

**16**

**2**

**17**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**42**

**26**

**32**

**23**

**41**

**25**

**31**

**24**

 

**45**

**29**

**35**

**20**

**34**

**21**

**33**

**22**

**36**

**19**

**48**

**32**

**47**

**31**

**46**

**30**

**44**

**28**

**43**

**27**

**37**

**18**

**38**

**17**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Implant placement date: | | |  | | | | | | | | (dd/mm/aaaa) | | | | | | | | |
| Implant removal date: | | |  | | | | | | | | (dd/mm/aaaa) | | | | | | | | | Abutment removal | | | | | | | |  | | | | | (dd/mm/aaaa) | | |
| The implant removal was due to a problem with abutment or instrumental? | | | | | | | | | | | | | | | | | | | Yes | | |  | | | No |  | | | |
| In case of implant removal, it was replaced in the same surgical procedure? | | | | | | | | | | | | | | | | | | | Yes | | |  | | | No |  | | | |
| What was the applied torque? | Manual |  | | Wrench | | | | |  | | | |  | | |  | | N.cm | | | | | | | | | | |
| What was the bone quality found? Bone type | | | | | I | | |  | | | | II | |  | | | III | | | |  | | IV |  | | |
| Implant was placed right after tooth extraction? | | | | | | No |  | | | Yes | | | | |  | | If If yes, was there an infection? | | | | | | | | | | | | Yes | |  | No | |  |

What was the drills sequence used? Mark with an X:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Initial Drill** |  | **Twist Drill  2.0** |  | **Twist Drill 2.8** |  | **Twist Drill 3.0** |  | **Twist Drill 3.15** |  | **Twist Drill 3.3** |  | **Twist Drill 3.8** |  | **Twist Drill 4.3** |  | **Twist Drill 5.3** | |  | |
| **Alvim Drill**  **2.0** |  | **Alvim Drill**  **3.5** |  | **Alvim Drill 4.3** |  | **Alvim Drill 5.0** |  |  | | | | | | | | | |  | |
| **Pilot Drill**  **2/3** |  | **Pilot Drill 2.8/3.5** |  | **Pilot Drill 3/3.75** |  | **Pilot Drill 3.3/4** |  | **Pilot Drill 3.6/4.3** |  | **Pilot Drill 4.3/ 5** |  | **Pilot Drill 3.8/ 4.3** |  | **Pilot Drill 4.3/ 5.3** |  | **Pilot Drill 5.3/ 6** | |  | |
| **Countersink Drill 3.3** |  | **Countersink Drill 3.5** |  | **Countersink Drill 4.1** |  | **Countersink Drill 4.3** |  | **Countersink Drill 4.5/5.0** |  |  | | | | | | | |  |
| **Facility Drill 2.0** |  | **Facility Drill 10** |  | **Facility Drill 12** |  | **Facility Drill 14** |  | **Facility Bone Tap** |  |  | | | | | | | |  |
| **Others?** |  | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Was there any type of fenestration? | | | No | | | |  | | Yes | | | | |  |
| Was bone graft placed? | | | No | | | |  | | Yes | | | | |  | Which material? | | | | |  | | | | | |
| Data of abutment placed: | | Multiple | | | |  | | Unit | | |  | | Angled | | | |  | Straight | | |  |
| When it was installed? | Immediate | | |  | Late | | | | |  | | Date: | | | |  | | | (dd/mm/aaaa) | | | | Not yet |  |

**FACTORS THAT COULD HAVE INFLUNCED THE PROBLEM FOUND**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Diabetes Mellitus | |  | Insuficient bone quality |  | Biomechanical overload |
|  | Deficient oral hygiene | |  | Insuficient bone quantity |  | Immunodeficiency |
|  | Chemotherapy | |  | Sinus membrane perforation |  | Allergy/hypersensitivity |
|  | Occlusal trauma | |  | Radiotherapy (Head/neck) |  | Does not use oclusal splint |
|  | Surgical trauma | |  | Overheating of Bone |  | Perimplantitis |
|  | Infection | |  | Immediate load |  | Xerostomy |
|  | Smoking | |  | Bruxism |  | Alcohol use |
|  | Medication? |  | | | | |
|  | Other diseases? |  | | | | |
|  | Other? |  | | | | |

**THE IMPLANT LOSS WAS FOLLWED BY THE FOLLOWING EVENTS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Pain | |  | Fistula |  | There was no symptom |
|  | Hemorrhage | |  | Swelling |  | There was no control appointments |
| Other: | |  | | | | | |

**IN CASE OF REUSABLE PRODUCT**

**What product was used for cleaning?**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Enzymatic soap | | |  | Clorexidine 2% | | |  | | Glutaraldehyde |  | Saline |
|  | Álcohol 70% |  | Hydrogen peroxide | | |  | Others? | |  | | | | |

**Method used?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Manual |  | Ultrasound |

**Which material used in cleaning?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Nylon brush |  | Multipurpose sponge |  | Steel brush |  | Steel sponge |

**Is there any difficult related to the product use?**

|  |
| --- |
|  |
|  |

**COMMITMENT AGREEMENT**

I declare that the information above is true and is consistent with the patient’s file.

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | | |
| Signature: | |  | |
| Name of the responsible for the information: | | |  |

**STERILIZATION DECLARATION**

|  |  |  |
| --- | --- | --- |
| I, |  | , declare that the items described above |

were properly sterilized within the ideal standards.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Method of sterilization | | | |  | Moist heat (Autoclave) | | | | | | | | |
| Number of biologial indicator batch *(Bacillus stearothermophilus)* | | | | | | | | | | |  | |
| Result of biological indicator: | | | | | |  | SATISFACTORY (abscence of biological indicator growth) | | | | | | |
|  | | | | | |  | UNSATISFACTORY (presence of biological indicator growth) | | | | | | |
| Sterilization date: | | |  | | | | | | | | | |
| Model of sterilization equipment: | | | | | | | |  | | Serial number: | |  |
| Manufacturer: | |  | | | | | | | Capacity (liters): | | |  |
| Responsable for sterilization: | | | | |  | | | | | | | |
| Signature: |  | | | | | | | | | | | |

**It is recommended that the sterilization should be done with temperature of 121ºC, at 1 atm of pressure and the cycle time should be of 30 minutes.**

**ATENTION! How to proceed when sending the product for analysis**

1. The products must be sent to one of the following addresses:

1. **Products purchased in one of NEODENT branches in BRASIL:** exclusively to Customer Services of NEODENT, at Av. Juscelino Kubitschek de Oliveira Avenue 3291, CIC / Postal Code: 81270-200, city of Curitiba, State of Paraná, Brazil.
2. **Products purchased in a NEODENT Authorized Distributor**: return directly to the Authorized Distributor where the product was bought.

2. The product must be sent to Neodent/Authorized Distributor/Subsidiary properly packaged in self-adhesive surgical grade paper packaging with laminated film, with sterilization confirmation by means of specific tapes for autoclave;

3. All products must be sent to Neodent/Authorized Distributor/Subsidiary completely cleaned and sterilized, with the warranty form filled and with all the documents:

a) Copy of purchase invoice;

b) Warranty form filled, with all asked data (when allowed);

c) Copy of patient’s clinical file;

d) Radiographs, being assured the return to the professional after Neodent analysis.

**Note:** For the countries that the legislation does not allow patient’s information, these data does not apply.

**4. Products which are not cleaned and sterilized and with the respective sterilization confirmation will not be received and accepted for analyze and will be discarded.**

5. The dentist assumes full responsibility for the costs of hiring a third company for sterilization of the products sent without observing the above instructions.

In case of queries, please contact the authorized Distributor/Subsidiary or Neodent Customer Service (only for products which were bought in Brazil) per email: [sac@neodent.com.br](mailto:sac@neodent.com.br) Phone number: 0800 725 6363 (Brazil) or 55 41 2169 4049.