

COMPLAINT QUESTIONNAIRE

- Please complete this form with as much detail as possible. Missing information will delay processing.
- Please provide the explanted product(s) in sterile condition

A. Customer Information	
Clinic Name	
E-mail	Phone Number
Implanting Dentist	
Country	
B. Product Information	
Type of Product	<input type="radio"/> Implant <input type="radio"/> Prosthetics <input type="radio"/> Instrument
Article Number	
Lot Number	
Product Returned	<input type="radio"/> yes <input type="radio"/> no
C. Patient Information	
Patient ID	
Age	<input type="radio"/> <20 <input type="radio"/> 20-50 <input type="radio"/> 50-70 <input type="radio"/> >70
Bone Type	<input type="radio"/> D1 <input type="radio"/> D2 <input type="radio"/> D3 <input type="radio"/> D4
Tooth Nr.	
History	<input type="radio"/> Smoker <input type="radio"/> Bruxes <input type="radio"/> Diabetics <input type="radio"/> No significant findings <input type="radio"/> Other _____
D. Surgery Information	
Date of implantation	-- / -- / ----
Date of prosthetic restoration	-- / -- / ----
Information on procedure	<input type="radio"/> Original TRI [®] Instruments used <input type="radio"/> Instruments cleaned, disinfected and sterilized before use <input type="radio"/> Bone augmentation procedure used <input type="radio"/> Other _____
E. Information about the incident	
Date of incident	-- / -- / ----
Oral hygiene around implant	<input type="radio"/> Excellent <input type="radio"/> Good <input type="radio"/> Average <input type="radio"/> Poor
Patients' symptoms	<input type="radio"/> Pain <input type="radio"/> Infection <input type="radio"/> Swelling <input type="radio"/> Dehiscence <input type="radio"/> Bone loss <input type="radio"/> Nerve Injury <input type="radio"/> Other _____
Description of the event	<input type="radio"/> Lack of primary stability <input type="radio"/> Lack of osseointegration <input type="radio"/> Mechanical malfunction of the product <input type="radio"/> Handling issue <input type="radio"/> Other _____ Please describe why you think the implant was lost or had to be removed _____ _____ _____ Could the patient be successfully retreated: <input type="radio"/> yes <input type="radio"/> no
F. Information about the incident	
Please send the completed form with the explanted product(s) in sterile condition to:	
TRI[®] Dental Implants	
ATTN: Complaint Handling	Questions
Merzhauserstrasse 183	E-Mail: complaints@tri-implants.swiss
79100 Freiburg	Fax: +41 32 510 1601
Germany	Phone: 00800 3313 3313
Upon receipt, TRI[®] Dental Implants will review your feedback and inform you. When all necessary information is received, replacement product(s) can be provided in a timely matter	
G. Signature & Date	