Form – PM

Please fill in the form in order to follow up customer complaints.

NOTE: Please also read the Information Sheet "Causes of Implant Failure"

Please transmit via email or fax to your Ritter Representative!

A. Information				
Dr. Name:				
Address:				
B. Medical Device Identification				
Dental Implant *(Information as mentioned on the product label)*	Types of implant/s [QSI, NL-QSI, TFI, SBLA or/and NL-SBLA]		Or REF:	
	Diameter (d) and length (l) of implant/s [mm] e.g. 6-8 mm (d-l):			
	Lot-No. LOT:			
Dental Abutment used with the dental implant mentioned above *(Information as mentioned on the product label)*	REF:			
	Lot-No. LOT:			
Surgical Kit for use with the above medical devices	☐ RIBEU-PE (Professional Kit) ☐ RIBUS-SE (Starter Kit) ☐ RIB-PROS (Prothetik Kit) ☐ GSKIT (Guided Kit) ☐ other _____ Drill Lot-No. … LOT._____			
C. Patient Information				
Anonymized patient no.:				
Weight [lb] / Height [ft in]:				
Tooth/s No./ Positions:				
Bone Density Type:		☐ I	☐ II	☐ III ☐ IV
Other relevant history:	Smoker:	☐Yes	☐No	
	Bruxing:	☐Yes	☐No	
	Clenching:	☐Yes	☐No	
	Good Oral Hygiene:	☐Yes	☐No	
	Bone Augmentation:	☐Yes	☐No	
	Pre-Existing medical condition:	☐Yes	☐No	
	Further comments (e.g. diabetes, arthroses):			
D. Chronology of Events				
Implant Placement Date [Date YYYY-MM-DD]:				
Date of failure/ removal of implant [Date YYYY-MM-DD] (only for failure):				

Form – PM

E. Event Description			
Description of Event: (Check one)	Lack of integration:	☐Yes	☐No
	Lost integration:	☐Yes	☐No
	Mechanical Failure:	☐Yes	☐No
	Other:		
	Was surgical procedure completed with different product from stock?	☐Yes	☐No
	If yes, was it immediate loading? (Less than 4 months)	☐Yes	☐No
What happened to the patient as a result of this event? **Please indicate by using Yes or No.**	Discomfort/ Soreness:	☐Yes	☐No
	Pain:	☐Yes	☐No
	Edema:	☐Yes	☐No
	Infection/Peri-implantitis:	☐Yes	☐No
	Surgical Intervention:	☐Yes	☐No
	Wound Dehiscence:	☐Yes	☐No
	Bone Loss:	☐Yes	☐No
	Further comments:		
Please attach digital X-ray/PAN/3D picture or analog	■ Picture enclosed		

I hereby confirm that the above information is complete, true and correct.

Date [Date YYYY-MM-DD]: _____

Stamp and Signature _____

_____

Only to fill out by Ritter Representative:

Received form on (date): Spare part request: ☐ yes ☐ no

_____

Corrective action: Date accomplished:

_____ _____

_____

Preventive action: Date accomplished:

_____ _____