CHAMPIONS

Return form that is to be completed in case of implant failure and non-osseointegrated implants

In accordance with the regulatory requirements, information on complaints about our products must be documented.
Please complete this return form in full and submit it within 90 days of failure.
Return: please return the questionnaire and X-ray pictures as well as sealed, autoclave-processed implants in a padded envelope.

1 Information on the dental office

Name of the dental office _____ Customer No. _____ Implantologist _____

2 Information on implant failures and appointments

Article number _____ Batch code _____ Date of the implant placement (DD/MM/YYYY) _____ Site _____

Immediate implantation ☐ Temporary denture (DD/MM/YYYY) _____ Final denture (DD/MM/YYYY) _____ Removal/Failure (DD/MM/YYYY) _____

3 Information about the patient

Patient number _____ Date of birth _____ ☐ Female ☐ Male

Medical history

- ☐ Diabetes mellitus
- ☐ Smoker
- ☐ Lowered immunity
- ☐ Exposure to radiation in the head/neck area
- ☐ Psychological problems
- ☐ Drug or alcohol abuse
- ☐ Chemotherapy at the time of the implantation
- ☐ Xerostomia
- ☐ Use of steroids
- ☐ Lymph vessel disorders
- ☐ Blood coagulation disorders
- ☐ **N.A.D. (disease, no appreciable)**
- ☐ Uncontrolled internal secretion
- ☐ Allergies: _____
- ☐ **Other** local or chronic systemic diseases that can influence the implant placement: _____

4 Information about surgery

Description of the problem

Was primary stability achieved? ☐ Yes ☐ No
Was the implant osseointegrated? ☐ Yes ☐ No
Was the Condenseur used? ☐ Yes ☐ No
Insertion of the implant ☐ Torque Wrench ☐ Handpiece

Bone quality ☐ Type I ☐ Type II ☐ Type III ☐ Type IV

Torque in Ncm _____

Was augmentation performed before or during surgery? ☐ No ☐ Yes If yes, what type of augmentation? _____

<u>In case the implant was placed and removed on the same day</u>, was another implant successfully placed? ☐ Yes ☐ No

If yes : Article number _____ Batch code _____

Were the following problems observed during surgery?

- ☐ Trauma/accident
- ☐ Implant fracture
- ☐ Deficiency in bone quality
- ☐ Biochemical overloading
- ☐ Poor oral hygiene
- ☐ Previous augmentation (date) _____
- ☐ Overheating of bone
- ☐ Immediate removal
- ☐ Proximity of teeth having undergone an endodontic treatment
- ☐ Treatment of nerves
- ☐ Peri-implantitis
- ☐ Infection
- ☐ Sinus lift
- ☐ Other _____

At the time of the implant failure, the following problems occurred (check where applicable):

☐ Pain ☐ Bleeding ☐ Swelling ☐ Numbness ☐ Mobility ☐ Fistula ☐ Asymptomatic ☐ Other

5 Information on the denture and loading/strain

- ☐ Temporary denture
- ☐ Final denture
- ☐ Removable denture
- ☐ Crown
- ☐ Telescope
- ☐ Tongue
- ☐ Bruxism
- ☐ Immediate loading
- ☐ Bridge

Was an original abutment used? ☐ No ☐ Yes If yes, Article number _____ Batch code _____

Signature/stamp of the doctor _____ **Date** _____