

Return Card

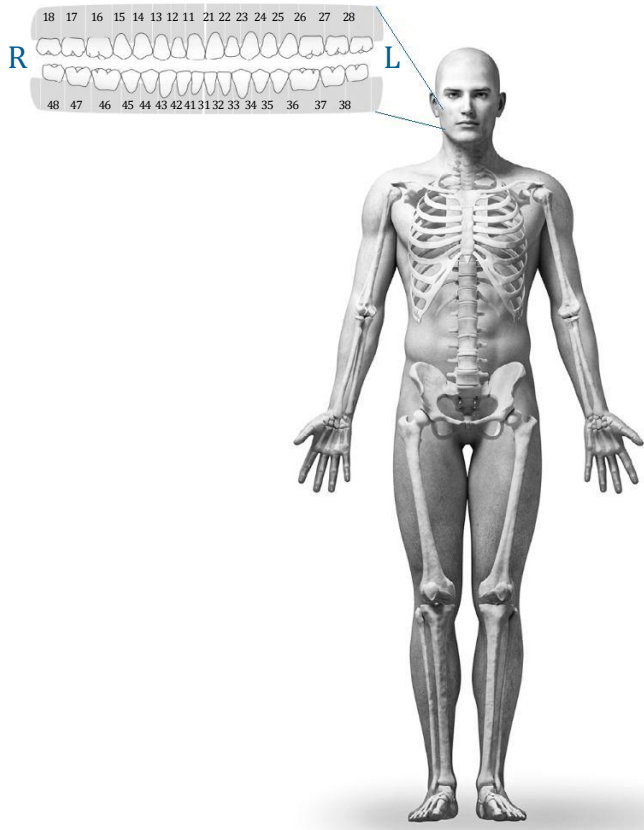
Transplantation of a non-vital allogenic tissue transplant

Hospital/TE Name of Hospital or Dental Clinic Doctor's/Dentist's Name	Date ddmmyyyy <input type="text"/> Stamp	Please send completed form to following email office@btmedical.com or call to +46 36 440 44 44
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Label Graft label please apply here	Order Number:
	SEC:
	Item-Number or Batch-Number:

Localization

Short description:



18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28
R L
48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38

Please circle the localization on graphic

Patient Info

Gender Male Female

Age

Unique Identity Number:

Indication:

Treatment

Nondescript

In the event of post-operative adverse reaction, please contact fh@btmedical.com

Co-used medical devices or combination products:

Other tissues (e.g. autologous):

Surgical procedure:

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V01 2024-09-20

This form does not collect personal data. If personal data is given, it will be blacked out and not further processed.