Special Products Implant Request Form

(As required by Section 520 (b) of the Food, Drug, & Cosmetic Act)

Please complete all fields

Physician's Name: _____

Phone Number: _____

Hospital Address: _____

_____

Zimmer Rep's Name: _____

Phone Number: _____

Territory: _____

Patient's Name: _____

Sex: _____ Age: _____

Height: _____ Weight: _____

If Revision-Current implant & Size: _____

_____

_____

** In association with this request, will or has any Zimmer product been revised?*

☐ Yes ☐ No ☐ Unknown

** In association with this request, is there reason to believe that a Zimmer product did NOT perform to expectation?*

☐ Yes ☐ No ☐ Unknown

** Has the Zimmer Product Experience Group been notified?*

Zimmer.PER@Zimmer.com

☐ Yes ☐ No

Applicable only if "yes or "unknown" was answered to questions 1 or 2 above

**Provide Complaint Number or "Unknown" (if not available at this time).* _____

Anatomic Location:

☐ Knee ☐ Elbow ☐ Trauma

☐ Hip ☐ Ankle ☐ Wrist

☐ Shoulder ☐ Dental

☐ Other _____

Bone / Joint (side) Requiring Prosthesis:

☐ Left

☐ Right

Indicated Use:

☐ Cemented

☐ Press-Fit

☐ Unknown

Approved MC: MC0000139023
Effective Date: 06/05/15

Detailed unique patient condition (or disease state) creating need for custom a device:

- ☐ Allergy _____
- ☐ Oncology
- ☐ Dwarfism
- ☐ Infection
- ☐ Anatomic Abnormality
- ☐ Fracture / Periposthetic
- ☐ Fracture
- ☐ Component Placement
- ☐ Component Loosening
- ☐ Bone / Joint Disease
- ☐ Bone Loss / Erosion
- ☐ Congenital Dysplasia
- ☐ Osteonecrosis
- ☐ Flexion Contracture
- ☐ Rheumatoid Arthritis
- ☐ Other Arthritis _____
- ☐ Hyperextension
- ☐ Limb Length Discrepancy
- ☐ Tissue Laxity / Tension
- ☐ Other _____

Please describe the requirements for the desired custom device:

I, the undersigned have determined that a custom device will be necessary to provide the most effective relief of a patient condition. The available standard production devices are not completely suitable for this purpose. I agree that the custom device described below will be used only by me or under my supervision and is intended for use for the patient named above.

Date: _____ Signature of the responsible ordering physician: _____

The custom made prosthesis may be manufactured and delivered only if this order is signed by the responsible physician.

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