

# DARF Retrieval Center

900 East Washington St., Suite 200, Colton, CA 92324  
(909)-882-5867 ext 119 • [darf@darf.org](mailto:darf@darf.org)

## Implant Retrieval Form

### **SURGEON INFORMATION:**

Retrieval Surgeon: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_\_ Fax #: \_\_\_\_\_

\_\_\_\_\_ E-mail Address: \_\_\_\_\_

Implant Surgeon (If different from yourself): \_\_\_\_\_

**(If you implanted the prosthesis please fill out below)**

Where you satisfied with the original size of prosthesis: Yes No Orientation: Yes No

Any complications? \_\_\_\_\_

Post-operative management? \_\_\_\_\_

Comments: \_\_\_\_\_

### **PATIENT INFORMATION:**

Name: \_\_\_\_\_ Male Female

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs Height: \_\_\_\_\_ in

Patient activity prior to onset of problems:

Nonambulatory Ambulatory w/ aid Active Fairly Active Very Active

Patient activity prior to surgery:

Nonambulatory Ambulatory w/ aid Active Fairly Active Very Active

Questions on pain:

Location: \_\_\_\_\_

Severity: (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Length: \_\_\_\_\_ months

Reason for implant: \_\_\_\_\_

Additional diagnoses prior to surgery: \_\_\_\_\_

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Is the patient taking any medications?      Yes    No

If so, please describe: \_\_\_\_\_

### **IMPLANT INFORMATION:**

Manufacturer: \_\_\_\_\_ Model: \_\_\_\_\_      Left    Right

Implant LOT # \_\_\_\_\_ Identification Sticker: Yes    No

Date of Implantation:    /    /      Date of Retrieval      /      /

Was the implant a:    *Primary*                      *Revision*                      *Unknown*

Why was this prosthesis removed?    *loose*    *subsidence*    *painful position*

*instability*      *dislocation*      *lysis*

*wear of implant*                      *fracture of implant*  
*sepsis*                      *postmortem*                      *other:*

What was the quality of the bone at the time of revision:    *poor*    *fair*    *good*    *excellent*

Was there evidence of significant debris?    *no*    *poly*    *metal*    *cement*                      *other:*

Lytic activity at revision:                      *none*    *mild*    *moderate*    *severe*                      *Location:* \_\_\_\_\_

Loosening?                      *none*    *mild*    *moderate*    *severe*

Stress shielding?                      *none*    *mild*    *moderate*    *severe*

Osteoporosis?                      *none*    *mild*    *moderate*    *severe*

Difficulty of removal:                      *non*    *mild*    *moderate*    *severe*

Instruments used in removal: \_\_\_\_\_

Replacement prosthesis      Manufacturer: \_\_\_\_\_      Model: \_\_\_\_\_

*Thank you for taking the time to provide us with this information. A letter will be sent out up to one week after we receive your retrieval with your information.*