



ALLOGRAFT ORDER FORM

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PATIENT/PROCEDURE INFORMATION					ORDER/DELIVERY DETAILS		
RECIPIENT (Name)					ORDER DATE		
RECIPIENT ADDRESS					ORDER PLACED BY		
					CONTACT PHONE		
					DELIVER TO (attention of)		
DATE OF BIRTH					CONTACT PHONE		
UNIT RECORD NUMBER					DELIVERY DATE/TIME		
RHESUS FACTOR					DELIVERY ADDRESS		
SURGERY DATE							
SURGEON							
HOSPITAL					HOSPITAL FAX		
SURGERY DESCRIPTION							
ALLOGRAFT REQUIRED							
MILLED BONE (Particle Size)	QUANTITY REQUIRED (Weight: 1g \cong 2cc)					OTHER	DETAILS e.g. dimensions/quantity
	<5g	5-9g	10-19g	20-29g	30-50g		
COARSE (8 – 10mm)						WHOLE FEMORAL HEAD	
FINE (5 -8 mm)						FEMORAL/TIBIAL STRUT	
ULTRA FINE (0.5 – 1mm)						WEDGE	
ULTRA FINE (0.5 – 1mm)						TENDON	
OTHER ALLOGRAFT							
ADDITIONAL INFORMATION							
PLUSLIFE USE ONLY							
ORDER RECEIVED BY:	DATE:	TIME:				ORDER ID #:	