Phone: 800-683-2400
Fax: 813-886-1851
www.lifelinktb.org

9661 Delaney Creek Blvd.
Tampa, FL 33619

Meniscus Allograft Order Form

Facility Name: ______________________________ Order Date: ______________

Requesting Physician: __________________________ Surgery Date: ______________

Patient Name: ____________________ Height: _____ Weight: _____ Gender: M F

City, State: ______________ **PO#**: ____________

Distributor Rep Name: ___________________ Rep Cell#: ___________

Office Contact Name: ____________________ Phone#: ____________ Fax#:_______

OR Contact Name: _____________________ OR Contact Phone #: _________________

Meniscus Allograft

Frozen Meniscus Grafts: (please circle) Left Right Medial Lateral

Required Specifications: ___________________________________

☐ Instrumentation required (lateral only)

***Please submit A/P and lateral x-rays with magnification markers to LifeLink Tissue Bank for graft sizing.**

To be filled out by LLTB personnel

Width (B): ______ Tibial Plateau Width (F): _______ Medial A/P (G): _______

Measured By: ____________________ LLTB ASC: ______________