Fresh Osteochondral Allograft Order Form

Hospital Information:

Hospital: ______________________________

Hospital Contact: ______________________

Hospital Contact Phone #: _______________

Patient ID/Initials: ______________________

Doctor: _________________________________

Date of Order: __________________________

Distributor: _____________________________

Rep.: __________________________________

Rep Phone #: ___________________________

PO#: ___________________________________

Instruments Required? Yes

Fresh Osteochondral Allografts: (Returns not available)

Catalog #	Description	
98F001	Hemi Condyle, Left Lateral	
98F002	Hemi Condyle, Right Lateral	
98F003	Hemi Condyle, Left Medial	
98F004	Hemi Condyle, Right Medial	

Catalog #	Description	
97F001	Talus, Left	
97F002	Talus, Right	

Defect Size: ________________mm

Allograft specifications:

To be Completed by LifeLink Hospital Services Dept.

Account #: _______________

Allograft Map: Sent Received Physician Approval Form: Sent Received

MUST BE WRITTEN ON BOX: ____

Ship Date: ____________ Surgery Date: ______________ Time of Surgery: ______________

Customer FedEx Account: Account #: ___________________________

Federal Express: P-1 8 AM Rep P/U:

Deliver via Courier: Courier Job #: __________________________

Shipping Fee: _____________ Total including shipping Fee: _____________

Fax completed form to: 813-886-1851 or email to: fresh@lifelinktissuebank.org