Graft Request Form with Required Compatibility

REQUEST COMING FROM OUTSIDE OF QUÉBEC? ○ YES ○ NO Account number _____

SURGEON

First Name	Last Name
Cell	Office
Email	

HOSPITAL

Name	
Address	
Contact Name	Contact Phone
Contact Email	

REPRESENTATIVE INFORMATION

Arthrex Name	**Arthrex** Email	**Arthrex** Phone
ConMed Name	**ConMed** Email	**ConMed** Phone

PATIENT INFORMATION

First Name	Last Name
Height cm/feet	Date of birth
Weight Kg/lbs	Date of surgery

Gender	○ Man	○ Woman
Instrument kit needed	○ Yes	○ No
Imaging	○ X-RAY	○ MRI/CT
Return films	○ Yes	○ No
Match needed	○ Yes	○ No

ADDITIONAL INFORMATION

Patient diagnosis and surgical procedure	Comments

GRAFT INFORMATION

Contralateral	○ Left	○ Right	○ No preference
Storage method	○ Fresh	○ Frozen	○ No preference

FROZEN OSTEOARTICULAR

BONE TYPE

- ☐ Femur
- ☐ Tibia
- ☐ Fibula
- ☐ Glenoid
- ☐ Humerus
- ☐ Radius
- ☐ Ulna
- ☐ Elbow
- ☐ Hemi-Pelvis
- ☐ Acetabulum
- ☐ Other

CONFIGURATION

- ☐ OA
- ☐ APC
- ☐ LG Graft
- ☐ With Cuff
- ☐ Without Cuff
- ☐ Proximal
- ☐ Distal
- ☐ Whole
- ☐ With Extensor Mech (BTB)

FROZEN MENISCUS

Whole Meniscus	○ Left	○ Right
Medial Meniscus	○ Left	○ Right
Lateral Meniscus	○ Left	○ Right

FRESH OSTEOCHONDRAL GRAFTS

Humeral Head	○ Left	○ Right
Patella w/ attachment	○ Left	○ Right
Patella	○ Left	○ Right
Femoral Condyles	○ Left	○ Right
Talus	○ Left	○ Right
Distal Tibia	○ Left	○ Right
Ankle	○ Left	○ Right
Tibial Plateau w/ Meniscus	○ Left	○ Right
Femoral Head	○ Left	○ Right
Medial Femoral Condyle	○ Left	○ Right
Lateral Femoral Condyle	○ Left	○ Right

ADDITIONAL DESCRIPTION

Dimension	Quantity

Héma Québec

Please send the form and the imaging (.zip file) at osteochondral@hema-quebec.qc.ca

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