P.O. Box 309
2300 AH Leiden, The Netherlands
www.bislife.org
email: bone@bislife.org
tel: +31 71 4083910
fax: +31 71 4083990

Bone Massive Allograft Request Form

Centre			
Phone		**Fax**	
Physician			
Patient	Male / Female	Date of birth	

Planned Surgery	Date Operation	
Diagnosis		
Surgical Procedure		

Allograft	❒ Left	❒ Right	
❒ Femur	❒ Tibia	❒ Fibula	❒ Humerus
❒ Proximal	❒ Distal	❒ Whole	❒ Diaphysis
❒ Other graft			
Use of Graft	❒ in combination with prosthesis ❒ as osteo-articular ❒ as intercalary	❒ as inlay or onlay ❒ for joint reconstruction ❒ other –> fill out remarks	
X-ray required	❒ Yes	❒ No	
Measurements (see drawing attached)	L mm	B mm	D mm
	M mm	A mm	BC mm

Remarks	

The undersigned, in the function of medical doctor, declares that his/her above mentioned patient agrees to provide the above mentioned data to BISLIFE for the purpose of his/her registration as a possible transplant recipient and to match these data against the data of a possible donor. The undersigned furthermore declares that his/her patient has given permission to use the data that will become available after transplantation, as far as they are required to optimize the sharing program of BISLIFE.

Date (dd/mm/yy). . / . . / . .	Name of MD:	Signature MD