MENTOR	MemoryGel™ Round Implant Device Tracking Form	**DEVICE TRACKING FORM** *Please type or **legibly** print **all requested information***

I. DEVICE INFORMATION (Required)

Date Implanted: |__|__| |__|__| |__|__|__|__|
Month Day Year

☐ Right Side—No Implant

☐ Left Side—No Implant

Place RIGHT Patient Record Label here or write in below:

Serial Number:_____

Place LEFT Patient Record Label here or write in below:

Serial Number:_____

II. DISCARDED/DESTROYED DEVICES—Provide serial number for any discarded/destroyed devices

Serial Number(s): _____

III. PATIENT INFORMATION

☐ Patient Refusal to Release Patient Identifying Information (Non-Patient specific information must still be collected.)

Name: _____ Telephone: (____)_____
Last First MI

Address: _____
Street Address

_____
City State Zip Code County

Social Security Number:_____-_____-_____ ☐ Patient Death: Date: |__|__| |__|__| |__|__|__|__|

IV. IMPLANTING/EXPLANTING SURGEON INFORMATION (Required)

Fax: (____)_____

Name: _____ Telephone: (____)_____
Last First MI

Address: _____
Street Address

_____
City State Zip Code Country

V. PRIMARY PHYSICIAN INFORMATION (if other than surgeon) ☐ N/A

Name: _____ Telephone: (____)_____
Last First MI

Address: _____
Street Address

_____
City State Zip Code Country

VI. EXPLANATION FOR ANY UNAVAILABLE INFORMATION

Specify: _____

_____

VII. IF THIS DEVICE IS REPLACING A PREVIOUSLY IMPLANTED MENTOR GEL DEVICE: ☐ N/A

Previous Device Serial Number(s):_____ _____ ☐ N/A

Device was: ☐ Returned to Mentor on: |__|__| |__|__| |__|__|__|__|

☐ Discarded/Destroyed

Please FAX Tracking Form to 866-216-4164