

Phone: 800-683-2400
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8510 Sunstate St.
Tampa, FL 33634

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: _____