

Patient ID	_____
Physician ID	_____
Clinic/Site ID	_____
Form filled out by (check one):	
<input type="checkbox"/> Physician _____	<input type="checkbox"/> NP/PA _____
<input type="checkbox"/> Resident _____	<input type="checkbox"/> Other _____

0.0.0, 104.52, 104.53, 101.6

# Implant Code Form

## TOTAL KNEE REPLACEMENT FORM 16.4C

TO BE COMPLETED BY **PHYSICIAN** FOR DESIGNATION OF KNEE  
PROSTHESIS IMPLANT CODE

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TODAY'S DATE IS: \_\_\_\_/\_\_\_\_/\_\_\_\_  
month day year

104.49

PHYSICIAN IMPLANT CODE FORM  
KNEE REPLACEMENT FORM 16.4c

1. PROSTHESIS MANUFACTURER (check one): 100.1288

- |              |                          |                 |                          |
|--------------|--------------------------|-----------------|--------------------------|
| a. Richards  | <input type="checkbox"/> | f. Kirschner    | <input type="checkbox"/> |
| b. Depuy     | <input type="checkbox"/> | g. Biomet       | <input type="checkbox"/> |
| c. Zimmer    | <input type="checkbox"/> | h. Osteonics    | <input type="checkbox"/> |
| d. Howmedica | <input type="checkbox"/> | i. ExacTech     | <input type="checkbox"/> |
| e. J & J     | <input type="checkbox"/> | j. Other: _____ | <input type="checkbox"/> |

2. PROSTHESIS NAME (check one): 100.1289

- |                         |                          |                 |                          |
|-------------------------|--------------------------|-----------------|--------------------------|
| a. Genesis              | <input type="checkbox"/> | f. PCA Modular  | <input type="checkbox"/> |
| b. Maximum Contact      | <input type="checkbox"/> | g. Duracon      | <input type="checkbox"/> |
| c. AMK                  | <input type="checkbox"/> | h. PCA Revision | <input type="checkbox"/> |
| d. Install/Burnstein II | <input type="checkbox"/> | i. TC IV        | <input type="checkbox"/> |
| e. Miller/Gallante      | <input type="checkbox"/> | j. Other: _____ | <input type="checkbox"/> |

3. PROSTHESIS DESIGN (check one): 100.1290

- |                               |                          |                         |                          |
|-------------------------------|--------------------------|-------------------------|--------------------------|
| a. Unicompartmental (medial)  | <input type="checkbox"/> | c. Patellar Replacement | <input type="checkbox"/> |
| b. Unicompartmental (lateral) | <input type="checkbox"/> | d. Total                | <input type="checkbox"/> |

4. PROSTHESIS TYPE (check all that apply): 100.1291

- |                         |                          |                 |                          |
|-------------------------|--------------------------|-----------------|--------------------------|
| a. Hinged               | <input type="checkbox"/> | f. Flat tibia   | <input type="checkbox"/> |
| b. Constrained condylar | <input type="checkbox"/> | g. Lipped tibia | <input type="checkbox"/> |
| c. Total condylar       | <input type="checkbox"/> |                 |                          |
| d. PCL preserving       | <input type="checkbox"/> |                 |                          |
| e. Posterior stabilized | <input type="checkbox"/> |                 |                          |

5. PROSTHESIS DESIGN (check all that apply): 100.1104

- |                        | Femur                    | Tibia                    |
|------------------------|--------------------------|--------------------------|
| a. Peg                 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Fin                 | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Intramedullary stem | <input type="checkbox"/> | <input type="checkbox"/> |

6. PROSTHESIS MATERIAL (check all that apply): 100.1292

- |                                    | Femur                    | Tibia                    | Patella                  |
|------------------------------------|--------------------------|--------------------------|--------------------------|
| a. Cobalt-chromium                 | <input type="checkbox"/> |                          |                          |
| b. Cobalt-chromium ion impregnated | <input type="checkbox"/> |                          |                          |
| c. Titanium Alloy                  | <input type="checkbox"/> |                          |                          |
| d. Titanium Alloy ion impregnated  | <input type="checkbox"/> |                          |                          |
| e. All poly                        |                          | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Metal back (cobalt-chromium)    |                          | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Metal back (titanium)           |                          | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ceramic                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Other: _____                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Not applicable                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

7. PROSTHESIS FIXATION (check all that apply): 100.1105

- |                                | Femur                    | Tibia                    | Patella                  |
|--------------------------------|--------------------------|--------------------------|--------------------------|
| a. Cemented design             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Cementless/press fit design | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

8. PRE-COATING OF IMPLANT (WITH PMMA) (check one): a. Yes  b. No  100.1107