



(800) 827-5775 Fax (805) 384-2792  
www.kinamed.com

Patient Name \_\_\_\_\_

Surgeon Name \_\_\_\_\_

Surgery Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Affix Patient sticker)

Date        /        /       

Hospital \_\_\_\_\_

Street \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Sales Rep \_\_\_\_\_

Purchase Order No. \_\_\_\_\_

SEND REPLACEMENT TO:

STREET:

CITY:

STATE:

ZIP:

Shipping/Handling:	
Total:	

### Special Instructions

*Kinamed Customer Service to Complete this section:*

INVOICE #

LOCATION &amp; TRANSFER #

INITIAL

SALES ORDER #
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