

3827 Creekside Lane Holmen, WI 54636

**BILLING INFORMATION**

\_\_\_\_\_  
Bill to Name

\_\_\_\_\_  
Street Address

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

\_\_\_\_\_  
Telephone                      Fax

\_\_\_\_\_  
Email

**SHIPPING INFORMATION**

Same as Billing Information     Check if Residential Address

\_\_\_\_\_  
Ship to Name

\_\_\_\_\_  
Street Address

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

\_\_\_\_\_  
Telephone

Please ensure the order form has thoroughly completed and signed, thank you.

**THE SYSTEM INCLUDES:**

- Custom made cushion with cover
- Control box with cover
- Smart charger

I am ordering (please check one of the following):

- Complete System** \$3,900.00
- Cushion Only** \$670.00 (To order a cushion only, you need to already own our APK2 controller)

**PAYMENT INFORMATION**

Name on card: \_\_\_\_\_

Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_

Security Code: \_\_\_\_\_

**Aquila does not bill to insurance companies**

**CUSHION SIZE:** \*Order only in whole inches\* \_\_\_\_\_ inches (wide) X \_\_\_\_\_ inches (deep)

Each cushion includes choice of either one 4-way stretch breathable cover or incontinent cover.

\* Please indicate your preference:  4-way stretch breathable     Incontinent

**OPTIONAL ACCESSORIES:**                      \*Additional fees apply\*

- |   |  |
|---|--|
| <input type="checkbox"/> Wireless Remote Control (\$299.00) | <input type="checkbox"/> Moisture Control Unit (MCU) (\$225.00)  |
| <input type="checkbox"/> Pelvic Positioning Pad (\$85.00)   | <input type="checkbox"/> Hand-inflated Lumbar Cushion (\$180.00) |
| <input type="checkbox"/> Wheelchair Backpack (\$150.00)     | <input type="checkbox"/> 1-year extended warranty for \$250      |

Would like any **additional** covers:     Incontinence cushion covers do not work with the moisture control unit   

Extra 4-way stretch breathable cushion cover:                      (quantity)     Incontinence cushion cover:                      (quantity)

**CLIENT INFORMATION:**

1. Client Name: \_\_\_\_\_ Age: \_\_\_\_\_ Client Weight: \_\_\_\_\_ Lbs.

Diagnosis: \_\_\_\_\_

2. Do you have any sores now? Yes  No  \*If yes, you must complete the pressure sore location and information section on pg 2.

3. Have you had flap surgery or is flap surgery scheduled for the near future? Yes  No  Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

4. Do you have prominent ischial bones? Yes  No

5. Do you have sensation in your posterior area? Full  Some  None

6. Does your wheelchair tilt? Yes  No

7. Will your cushion be placed directly on a metal seat pan? Yes  No

8. Do you have a severe lean to either side? Left  Right  No

9. Do you sit with your ischial bones equally distant from the front/rear of the cushion? Yes  No

If no, please provide measurements of each ischial bone in relation to the front/rear of the cushion:

\_\_\_\_\_  
Otherwise, please provide photos of the client sitting in their wheelchair to show their positioning.

# Detailed measurements for custom fabricating APK2 Cushion System:

## CURRENT CUSHION DATA:

1. What kind of cushion are you currently using? \_\_\_\_\_

## PRESSURE SORE LOCATION AND INFORMATION:

Mark the sore locations (A, B, etc.) on the diagram and indicate the stage and size of each sore.

- Sore A Stage: \_\_\_\_\_ Size: \_\_\_\_\_ cm (length) \_\_\_\_\_ cm (width)
- Sore B Stage: \_\_\_\_\_ Size: \_\_\_\_\_ cm (length) \_\_\_\_\_ cm (width)
- Sore C Stage: \_\_\_\_\_ Size: \_\_\_\_\_ cm (length) \_\_\_\_\_ cm (width)
- Sore D Stage: \_\_\_\_\_ Size: \_\_\_\_\_ cm (length) \_\_\_\_\_ cm (width)

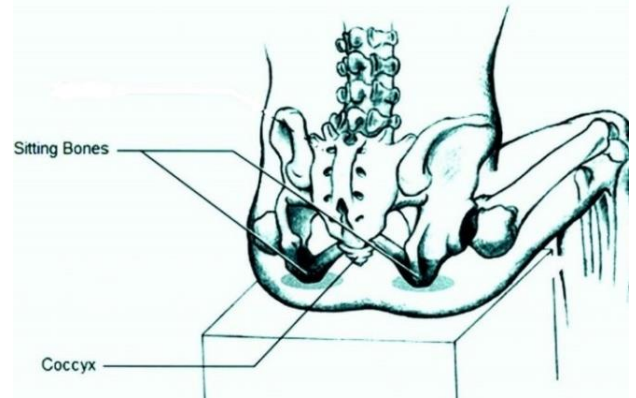
**\*\*Providing exact location of your sores in relation to your cushion is required. For example, how many inches from the right or left of the cushion and how many inches from the front or rear of the cushion is the center of the sore? \*\***

### **Please clearly list measurements for each sore:**

Sore A: \_\_\_\_\_ inches from back of the cushion \_\_\_\_\_ in from front \_\_\_\_\_ in from the left \_\_\_\_\_ in from the right  
Sore B: \_\_\_\_\_ inches from back of the cushion \_\_\_\_\_ in from front \_\_\_\_\_ in from the left \_\_\_\_\_ in from the right  
Sore C: \_\_\_\_\_ inches from back of the cushion \_\_\_\_\_ in from front \_\_\_\_\_ in from the left \_\_\_\_\_ in from the right  
Sore D: \_\_\_\_\_ inches from back of the cushion \_\_\_\_\_ in from front \_\_\_\_\_ in from the left \_\_\_\_\_ in from the right

Any additional information (ex. Pelvic obliquities, need of low/high profile, additional pressure sore information, leg amputations, positioning uniqueness, other need-to-know factors, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



### **How did you hear about Aquila and our APK2 Cushion System?**

- Magazine Advertisement (Name of magazine): \_\_\_\_\_
- Website Advertisement (Name of the website): \_\_\_\_\_
- Web Search     Referral from clinician     Recommendation from family or friend     Trade show or presentation

### **🌀 Advisory Notice 🌀**

- Please be advised that healing may occur very quickly. Please limit your sitting time and gradually increase your sitting time as advised by your physician.
- Tissue health is the responsibility of each individual. It is also up to each individual to inspect their skin at least once daily for any signs of redness of the skin or changes in any existing sores and take appropriate action.
- All international sales are final.

*30-day Return policy from delivery date minus 30% Customization Recovery Fee of total  
All information provided to Aquila will be kept confidential*

\_\_\_\_\_  
Signature (NOT VALID WITHOUT SIGNATURE)

\_\_\_\_\_  
Date