SofTech Seating System Order Form

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Product information

SofTech is a completely self-contained system with the electronics built into the cushion, rather than in a separate controller like our popular APK2 cushion system. Like the APK2, the SofTech seating system is designed to prevent and treat pressure ulcers while stimulating circulation. The SofTech seating system is <u>$4,300.</u>
<u>HCPCS Code:</u> E2609

<u>***Aquila does not bill insurance. ***</u>

SofTech Seating System contains:

- ❖ The custom cushion, built and programmed specifically for each client
- ❖ Cushion cover
- ❖ Smart Charger

Billing Information:

Bill to name	
Street Address	
City, State, Zip	
Credit Card #	________ -__________-_________ - ________
Expiration Date	_____ / ________ Security Code: ________
Telephone	
Email	

Shipping Information:
❑ Same as Billing Information
❑ Check if Residential

Ship to name	
Street Address	
City, State, Zip	
Telephone	
Email	

<u>CUSHION SIZE:</u>

What size cushion are you ordering? ___________inches (wide) X ___________ inches (deep).
Each cushion includes your choice of either one 4-way stretch breathable cover <u>or</u> one incontinent cover
*** Please mark your preference:** ❑ **4-way Stretch breathable** ❑ **Incontinent**

OPTIONAL ACCESSORIES: (Additional Fees Apply)

❑ Positioning Pad ($85.00)
❑ Moisture Control Unit ($225.00)
❑ Wheelchair Backpack ($150.00)
❑ Hand-inflated Lumbar Cushion ($180.00)
❑ Full Alternating Back Pad ($670.00)
❑ 1-year extended warranty for $350.00

*Please indicate if you would like any <u>additional</u> covers ($120.00 each).

❑ Extra regular cushion cover _____ *(quantity)* ❑ Extra incontinent cushion cover _____ *(quantity)*

Incontinent cushion covers do not work with the moisture control unit

CLIENT INFORMATION: (*This information is necessary to design a system specifically to your needs*)

Client Name: ____

Date of Birth: ______/______/_______

Client Weight: ___________ Lbs. Client height: _____' ______'' Diagnosis: ___________________________

Do you have any sores now? ❑ Yes ❑ No

***If yes, please complete the pressure sore location and information section on page 3.**

Have you had a flap surgery? ❑ Yes ❑ No Are you scheduled for flap surgery? Date_____/_____/______

Will the cushion sit directly on a metal seat pan? ❑ Yes ❑ No

Do you have prominent ischial bones? ❑ Yes ❑ No

Does your wheelchair have stand-up capabilities? ❑ Yes ❑ No

Does your wheelchair tilt? ❑ Yes ❑ No

If yes, what percentage of the time are you in tilt? __________%

Do you have sensation in your posterior area? ❑ Yes ❑ No ❑ Some

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

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

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

____

Otherwise, please provide photographs of the client sitting in their wheelchair to show their positioning.

Additional information on your condition or sores. ____

____

Any Information Provided to Aquila Corporation will be kept confidential

Current cushion information:

Your current cushion size: _____ inches (wide) X _____ inches (deep)

What kind of cushion are you currently using? _____________________________

Wheelchair information:

Between arm rests (width of seat pan)_____inches wide X front to back (depth of seat pan) _____deep

How did you hear about Aquila and our SofTech Seating System?

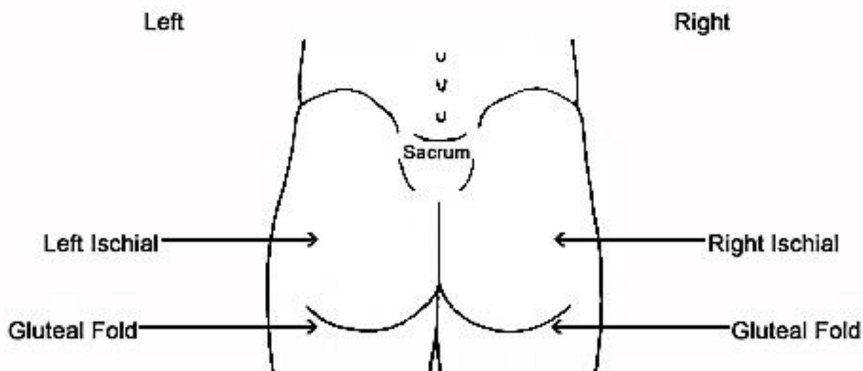
- ❑ Magazine Advertisement (Name of magazine: ____)
- ❑ Website Advertisement (Name of Website: ____)
- ❑ Web Search
- ❑ Referral from Clinician
- ❑ Recommendation from Family/Friend
- ❑ Trade Show

Pressure sore location and information:

- 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)

*****If you have had a recent Flap Surgery, mark the location with an F.**
*****If you have areas of sensitivity, mark the location with an S.**

Pressure sore location:



Any additional information (ex. Pelvic obliquity, need of low/high profile, additional pressure sore information, positioning uniqueness, etc.):

____
____
____
____
____
____
____

Providing exact location of your sores in relation to your cushion is <u>required</u>. 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 your pressure sore?

Please clearly list measurements for each sore:

Sore A: ____ inches from the back ____ in from the front ____ in from the left ____in from the right
Sore B: ____ inches from the back ____ in from the front ____ in from the left ____in from the right
Sore C: ____ inches from the back ____ in from the front ____ in from the left ____in from the right
Sore D: ____ inches from the back ____ in from the front ____ in from the left ____in from the right

ADVISORY NOTE:

** Please be advised that healing may occur very quickly. Please limit your sitting time and gradually increase sitting time as advised by your physician. Tissue health is the responsibility of each individual and it is up to the individual to monitor their skin and tissue at least daily. Follow all recommendations set forth by your physician. User assumes responsibility associated with the use of this product and releases Aquila from all claims. **

***30-day return policy from delivery date minus 35% Customization Recovery Fee of total. ***
All international sales are final.

Signature and Date: ____

(NOT VALID WITHOUT SIGNATURE AND DATE)