

SofTech Seating System Order Form



3827 Creekside Lane - Holmen, WI 54636
 Phone: 608.782.0031 Fax: 608.782.0488
 www.aquilacorp.com aquila@aquilacorp.com

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 \$4,300.
HCPCS Code: E2609

Aquila does not bill insurance.

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	

CUSHION SIZE:

What size cushion are you ordering? _____ inches (wide) X _____ inches (deep).

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

*** Please mark your preference:** 4-way Stretch breathable Incontinent

OPTIONAL ACCESSORIES: (Additional Fees Apply)

- | | |
|---|--|
| <input type="checkbox"/> Positioning Pad (\$125.00) | <input type="checkbox"/> Moisture Control Unit (\$250.00) |
| <input type="checkbox"/> Full Alternating Back Pad (\$700.00) | <input type="checkbox"/> Hand-inflated Lumbar Cushion (\$200.00) |
| | <input type="checkbox"/> 1-year extended warranty for \$350.00 |

*Please indicate if you would like any additional covers (\$130.00 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 of 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

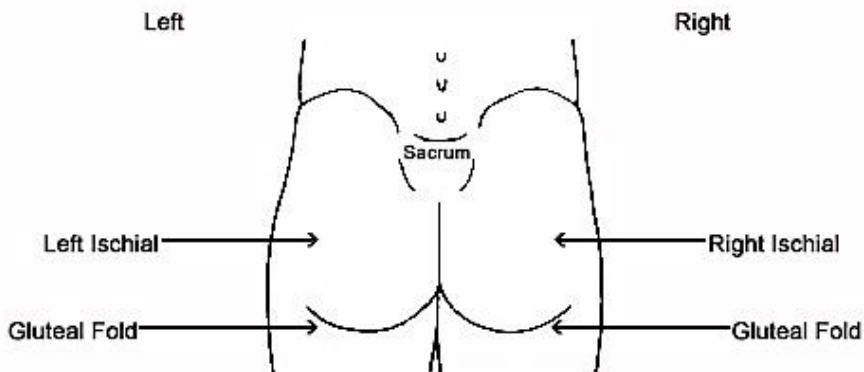
Pressure sore location and information:

- 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 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 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)

Effective 8/16/22