## Warranty Form

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|---|---|
| Date: | |
| Patient Name or ID: | |
| Recent change in patient's weight?: | ☐ Yes ☐ No |
| Patient weight | |
| Activity Level: | ☐ K1 ☐ K2 ☐ K3 ☐ K4 |
| Daily Activities: | |
| Length of time product used: | |
| Reason for return: | |
| Did patient sustain an injury? | ☐ Yes ☐ No |
| Describe injury: | |
| Was medical attention required? | ☐ Yes ☐ No |
| Clinician contact name: | |
| Clinician contact number: | |