# Service/Repair

ottobock.

Facility _____ PO# _____ Loaner PO# _____

Bill to Acct # _____ Ship to Acct # (if different than billing) _____

Contact _____ Tel/Fax/Email _____

Client Name/Identifier _____ Client Email _____

## Ottobock Office Use Only

Start Date: _____

Date Loaner Sent: _____

Date Arrived at OB: _____

Notification # IW51/52 _____

Work Order: VA01/02 _____

Returns Del: VRRE _____

Purch Req: _____

Purch Order: ME21/22 _____

Goods Recpt: MIGO _____

Delivery Note: _____

Invoice: _____

Components Model and Serial/Lot # _____

_____

_____

_____

_____

Original Purchase Date: _____

Last Repair Date: _____

Cdn Quote # _____

Quote Issued: VA21/22 _____

Quote Expiry Date: _____

Warranty ☐ Non-Warranty ☐ Estimate Required ☐

## Patient Data

| | | | |
|---|---|---|---|
| Weight | | Height | |
| Profession | | | |
| Relevant Sports and Leisure Activities | | | |
| Amputation Level | ☐ TF ☐ KD ☐ HD ☐ TT ☐ TR ☐ TH | Side of Amputation | ☐ Right ☐ Left ☐ Bilateral |
| Functional level (MOBIS®) | ☐ 1 ☐ 2 ☐ 3 ☐ 4 | Walking performance | kms/day |
| Special conditions outside of MOBIS ® | | | |

Which components does the prosthesis contain? (Please list article number)

| | | | |
|---|---|---|---|
| Hip Joint | | Hand Style | |
| Knee Joint | | Elbow Type | |
| Foot | | Electrodes | |
| Structural Components | | Other | |
| Harmony | | Other | |
| Other | | Other | |

Please fill in reverse side

Thank you very much for your assistance!

Ottobock After-Sales Service Department

## Description of the reason for complaint:

| **Functional Fault** | Failure description: |
|---|---|
| ☐ Stance/Swing Phase | |
| ☐ Stability | |
| ☐ Adhesion/Connection | |
| ☐ Pressure (vacuum) | |
| ☐ Wrist Rotation | |
| ☐ Open/Close | |
| ☐ Other | |

| **Mechanical Fault** | Failure description: |
|---|---|
| ☐ Break | |
| ☐ Cracks/Fracture | |
| ☐ Loose components | |
| ☐ Damage | |
| ☐ Other | |

| **Electrical** | Failure description: |
|---|---|
| ☐ Charging system | |
| ☐ Electrodes | |
| ☐ Wiring System | |
| ☐ Other | |

| **Other Fault** | Failure description: |
|---|---|
| ☐ Noise | |
| ☐ Play | |
| ☐ Loss of comfort | |
| ☐ Other | |

### Important Information Required – Critical Incident

Did the client fall? Yes ☐ No ☐

**If you answered YES to the above question, please fill in ALL of the fields below, otherwise leave blank.**

Was the fall due to device malfunction? Yes ☐ No ☐

Consequence: Loss of comfort ☐ Loss of function ☐ Allergy ☐ Collapse ☐ Injury ☐

Describe the injury if applicable:_____

Did the client seek medical attention? Yes ☐ No ☐ If Yes, what type of care: Ambulatory ☐ Hospitalization ☐

Was an authority notified? Yes ☐ Who: _____ No ☐

Date of event: _____ Age of Client: _____ Weight of Client: _____ lbs

Event Description (what was the client doing when the fall occurred?): _____

_____

_____

Thank you very much for your assistance!

Ottobock After-Sales Service Department