Equipment Pick-Up Verification

Patient/Facility Name (Print): _____ **DOB:** _____

Rep Name: _____ **Terr. ID:** _____

Start Date: _____

Stop Date (Required Field): _____

Pick Up Date (Required Field): _____

Pick-Up Location (check one):

☐ Patients Home

☐ Hospital

☐ Other _____

Equipment Description (check all that apply):

☐ CPM Device Serial #: _____

Initial Range of Motion: _____

End Range of Motion: _____

Time used: _____

☐ Other: _____ Serial #: _____

☐ Other: _____ Serial #: _____

Reason for Pick-Up (check one):

☐ Therapy completed

☐ Canceled surgery

☐ Replacement product require (swap)

☐ Other _____

Patient discontinued use of equipment on stop date listed above. The billing will stop effective that date.

_____ _____

Patient/Caregiver/Facility Representative Signature Date

FAX COMPLETED AND SIGNED FOR TO SYNERGY ORTHOPEDICS: (610) 292-0908