574 Robbins Drive • Troy, Michigan 48083
Toll-Free 888-344-0450 • Fax 248-588-5351

Hip Flexion Assist Device
Fitting Checklist

This form must be completed by the patient *and* the medical professional (physical therapist, orthotist, or physician) who issued the Hip Flexion Assist Device (HFAD). The completed form must be returned to BTM within 60 days of purchase to validate the warranty. The HFAD warranty covers manufacturer's defects for six months. Fax or mail completed forms to:

Fax: 248-588-5351

Mail: Becker Rehabilitation Products
Attn: HFAD
574 Robbins Drive
Troy, MI 48083

For Patient Use Only:

Check each box to indicate completion.

I hereby certify that I have:

- ☐ Received a copy of the HFAD User Instructions and have reviewed its contents.
- ☐ Received gait training for the HFAD from a physical therapist, orthotist, or physician.
- ☐ Received instruction for proper donning and doffing of the HFAD from a physical therapist, orthotist, or physician.
- ☐ Been fully advised about, and understand the use and limitations of the HFAD.

Patient Name: _____

Patient Signature: _____ Date: _____

For Medical Professional Use Only:

Check each box to indicate completion.

I hereby certify that I have:

- ☐ Reviewed the contents of the HFAD User Instructions with the patient.
- ☐ Provided HFAD gait training to the patient.
- ☐ Provided instruction for proper donning and doffing of the HFAD to the patient.
- ☐ Fully advised the patient about the use and limitations of the HFAD.

Name: _____ Title: _____

Signature: _____ Date: _____