



# BioWave No Risk In-Home Patient Trial Form

## Provider Information

Provider Name:	Facility/Dept:	Date Completed:
Preferred Email:	Length of Trial:	Notes:

## Patient Information

Name:	Phone:	Email:
Address for Delivery:	Last 4 of Social:	DOB:

Please select a maximum 2 BioWraps for the In-Home Trial:

Back BioWrap	<input type="checkbox"/> S/M Waist Size 28"-37"	<input type="checkbox"/> L/XL Waist Size 38"-50"
	<input type="checkbox"/> Back Extender Waist Size 51"-60" (Used with L/XL Back BioWrap)	
Knee BioWrap, Left & Right Compatible	<input type="checkbox"/> S/M Knee Circumference 12"-15.5"	<input type="checkbox"/> L/XL Knee Circumference 15.5"-19"
Thigh-Calf BioWrap, Left & Right Compatible	<input type="checkbox"/> One Size Min Circumference 12" Max Circumference 30" Fits Thigh, Calf, Biceps, Triceps, Hamstrings, Quadriceps, & IT-Band	
Foot-Ankle BioWrap, Left & Right Compatible	<input type="checkbox"/> S/M - Shoe Sizes: Men 5-9, Women 6-10	<input type="checkbox"/> L/XL - Shoe Sizes: Men 10-15, Women 11-16
Hand-Wrist BioWrap, Left & Right Compatible	<input type="checkbox"/> S/M Wrist Circumference 5.75"-7"	<input type="checkbox"/> L/XL Wrist Circumference 7"-8.5"
Migraine BioWrap	<input type="checkbox"/> One Size Circumference Around Neck 12" - 20"	

## BioWave In-Home Patient Trial

1. Please fill out and fax this form to BioWave at 475-444-3400 or email [orders@biowave.com](mailto:orders@biowave.com).
2. BioWave will process and ship a new device, 1 bag of electrodes and return label to the patient listed and notify provider of shipment/tracking information.
3. Patient will be trained on BioWave use/operation. \*We can help see below
4. Provider can then conduct their trial protocol for BioWave virtually, without the patient coming into the clinic or the provider going to the patients home, to determine if treatments are successful.
5. Trial Outcome
  - a. If successful, provider will notify BioWave of successful trial and submit consult for device and 1 bag of electrodes to prosthetics to pay for equipment. Prosthetics invoiced normally.
  - b. If unsuccessful, provider will notify BioWave and patient to ship device back to BioWave using provided label. BioWave will contact patient and coordinate returning device if necessary.

### Permission for BioWave to Contact Patients

Please check this box if you'd like BioWave to train your patient on the use and operation of the device.

Please contact patients for training only

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

