How to Use the Custom AGILITY Back System Order Form

ROHO® understands that the needs of your clients are unique. For that reason, we are offering the Custom AGILITY back.

You can now use ROHO’s DRY FLOATATION® technology to specifically address your client’s postural needs. You determine exactly what air cells you need and where, the size of the air cells, and how many compartments of adjustable air are required.

Order Form Example

STEP 1: Quick Release or Fixed Hardware

Check one

Quick Release
Quick Release hardware makes removal for transport or storage a snap, even by those with limited hand dexterity. Simply unlock it and lift it by the handle.

Fixed
Fixed hardware is ideal for clients who rarely need to remove their replacement backs (available in heights 16 inches and lower).

STEP 2: Each box on the featured shell can hold an air cell. Please determine where you would like air cells and the types of air cells needed.

1. 1” or 2.5 cm
2. LOW PROFILE® (2.25” x 5.5 cm)
3. MID PROFILE™ (3.25” x 8.5 cm)
4. HIGH PROFILE® (4.25” x 10.5 cm)

STEP 3: Custom AGILITY backs give you the options (or) option to create different adjustable air compartments. Please circle the compartments needed for this Custom AGILITY back.

STEP 4: Please note any special considerations, especially valve locations1, you would like our team to know about this custom AGILITY back.

SAMPLE: WHEELCHAIR BACK:

In this example, the clinician wanted MID PROFILE air cells in a separate adjustable lumbar support. The remaining cells are LOW PROFILE air cells that are also adjustable. Inflation valves come out of the bottom left of the AGILITY cover.

1Unless specified otherwise, valves will be placed toward the bottom of the custom AGILITY Back.
ORDER FORM

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☐ Quick Release ☐ Fixed

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PLEASE DO NOT SEND PATIENT-PROTECTED HEALTH INFORMATION. IT IS NOT NEEDED TO MAKE THIS PRODUCT.

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Please be advised that custom items take approximately 3 – 4 weeks from date of order to manufacture.

Provider/distributor name: ____________________________
ROHO account #: ____________________________
Circle one: QUOTE ORDER
Address line 1: ____________________________
Address line 2: ____________________________
City: ____________________________
State: ____________________________
ZIP: ____________________________
Country: ____________________________
Phone: ____________________________
Fax: ____________________________
E-mail: ____________________________
Person ordering: ____________________________
Reference name: ____________________________
P.O.# (required to place an order): ____________________________
Special instructions: ____________________________

**Decisions about how to code a product are the responsibility of the provider/supplier. Since Medicare coding is subject to change, the provider should always confirm the HCPCS code and coverage criteria as part of the client assessment process.**