Customer Clinical Complaint Questionnaire

Rev. F	Form No.: 1009

INMODE

Complaint No.	Received by:	
Date:	Time:	Ref:
Medical Director Info (if applicable)		
Physician name:	Specialty:	
Operator/Treatment Provider Name:		
Title:		
Usage duration of system:		
Clinic:	Address:	
Telephone:	Mobile:	
Fax:	Email:	
Contact Person (if different from operator):		
Device Info:		
System Name:	System S/N:	
Hand piece Type:	Hand Piece S/N:	
Software number:		
Patient Info:		
Code name:		
Gender: FEMALE	Age:	
Body Areas:	Skin Type:	
Treatment indication:		
Medications:		
Significant Diseases (Current and History):		
Any Tanning before or after Treatment?		
Was sunscreen applied on the treatment area during the entire treatment period?		
Was the treatment area shaved and cleaned? If YES, what was the area cleaned with? (e.g. cleanser, alcohol, soap):		
Were Test Spots performed? If YES, where were the Test Spots performed?		
How much time passed after test spot till the treatment?		
Did the patient complain of pain, tingling, discomfort, hot spots during the treatment? If Yes, please describe:		

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Number of previous sessions:
Number of Days/Weeks post last Treatment Sessions:
List any combined treatment regimen if used:
Patient signed ICF? ☐ Yes ☐ No
Were before and after photos taken? (note on photo and attach):
Describe the treatment given to the patient immediately post incident:
Patient's current clinical status and date:
Other Medical Info:
Incident Info:
Description:

Incident timing post treatment:	Incident recording date (e.g. photos) post treatment:

Minimally Invasive: BodyTite/FaceTite/NeckTite/AccuTite/Aviva/InMode RF:	
Applicator Name:	
Treatment depth (1-5 levels or mm):	
Protocol (according to IFU or other):	
End Points:	
Tumescent infiltration used & amount:	
Prep Solution:	
Post Op Care:	
Total Energy (kJ):	RF Power (W):
Total/Fat Aspirate (cc):	Cut-Off Temperature (C°) (external and internal when applicable):
Was the handpiece operational:	Was the handpiece saved:
Access Sites:	
Operating distance from access port:	
Was Conductive Gel used? ☐ Yes ☐ No Sterile? ☐ Yes ☐ No Which brand?	

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Fractora/FractoraV	
Sedative/Anesthesia (Ingredients %,duration):	End Points:
Energy (levels per pin):	
Number of pins: Number of stacks: Number of passes:	Post Op Care:
Tip Overlap (%):	
Protocol (according to IFU or other):	
Post Op Care:	

Forma/Plus	
Applicator:	Treatment Time per zone (min):
Treatment zone size:	
Energy (levels):	Cut-Off Temperature (C°):
Total Energy (kJ if applicable):	End Points:
Was Conductive Gel used? ☐ Yes ☐ No	If Yes, which brand?
Protocol (according to IFU or other):	
Post Op Care:	

BodyFX/MiniFX	
Applicator:	Treatment zone size:
Protocol (according to IFU or other):	
Power:	End Points:
Pulse Width (s):	Cut-Off Temperature (C°):
Post Op Care:	
Was any cream/gel used during the procedure? ☐ Yes ☐ No	

LUMECCA/DIOLAZE/DIOLAZE XL/TRITON	
Hand piece:	Wavelength:
Protocol (according to IFU or other):	
Fluence:	Pulse width:
Mode (pulses per second):	Cooling:
End points:	Number of passes:
Post Op Care:	
Was Conductive Gel used? ☐ Yes ☐ No	If Yes, which brand?

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FORMA V /Plus90		
Was pelvic exam performed: ☐ Yes ☐ No	If Yes, any abnormal findings?	
Hand piece:	Cut-Off Temperature (C°):	
Energy (levels):	External:	Internal: :
Treatment Time (min):	External:	Internal: :
Total Energy (kJ if applicable):	External:	Internal: :
Depth of internal treatment:		
Protocol (according to IFU or other):		
Was Conductive Gel used? ☐ Yes ☐ No	If Yes, which brand?	
Post Op Care:		

EVOLVE	
Applicator:	Units used for treatment (1-8):
Energy (levels):	Treatment Time (min):
Cut-Off Temperature (C°):	Patient Call Button tested:
Protocol (according to IFU or other):	
Were Conductive Gel Pads used? ☐ Yes ☐ No	If Yes, which brand?
Was Conductive Gel used? ☐ Yes ☐ No	If Yes, which brand?
Were belts used? ☐ Yes ☐ No	
Post Op Care:	

EVOKE	
Applicator:	Units used for treatment (1-8):
Energy (levels):	Treatment Time (min):
Cut-Off Temperature (C°):	Patient Call Button tested:
Protocol (according to IFU or other):	
Were Conductive Gel Pads used? ☐ Yes ☐ No	If Yes, which brand?
Was Conductive Gel used? ☐ Yes ☐ No	If Yes, which brand?
Were belts used? ☐ Yes ☐ No	
Post Op Care:	

MORPHEUS8	
Number of pins: Number of stacks: Number of passes: Depth:	Sedative/Anesthesia (Ingredients %,duration):
Energy (levels per pin):	Tip Overlap %:
Protocol (according to IFU or other):	
Post Op Care:	

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Please send high resolution photos (with dates) and any supporting documents such as charts, summaries, etc.
Please send responses to: **Dr. Hela Goren -** Hela.Goren@inmodemd.com **Dr. Eran Krieger** - Eran.Krieger@inmodemd.com **Mr. Yuli Baron-** Yuli.BarOn@inmodemd.com **Comments:**