



I N M O D E

Clinical Complaint Report Form

Complainant Name:	Click here to enter text.			
Name of Practice:	Click here to enter text.			
Date of Treatment:	Click here to enter a date.			
Workstation Used:	Choose an item.			
Workstation S/N:	Click here to enter text.			
Applicator Used:	<u>Non-Invasive RF</u> <input type="checkbox"/> Forma <input type="checkbox"/> Plus <input type="checkbox"/> BodyFX <input type="checkbox"/> MiniFX <input type="checkbox"/> FormaV	<u>Optical</u> <input type="checkbox"/> Lumecca 515 <input type="checkbox"/> Lumecca 580 <input type="checkbox"/> Diolaze 755/810 <input type="checkbox"/> Diolaze 810 <input type="checkbox"/> Diolaze 810/106 <input type="checkbox"/> Vasculaze	<u>Minimally Invasive</u> <input type="checkbox"/> Morpheus8 <input type="checkbox"/> BodyTite HP172206A <input type="checkbox"/> BodyTite HP172246A <input type="checkbox"/> BodyTite HP173906A <input type="checkbox"/> BodyTite HP253906A <input type="checkbox"/> BodyTite HP255006A <input type="checkbox"/> FaceTite HP101306A <input type="checkbox"/> FaceTite HP101806A <input type="checkbox"/> NeckTite HP122506A <input type="checkbox"/> CelluTite HP172248A <input type="checkbox"/> AccuTite HP060909A	<u>Hands-Free</u> <input type="checkbox"/> Evolve Tite <input type="checkbox"/> Evolve Trim <input type="checkbox"/> Evolve Tone <input type="checkbox"/> Evoke Cheek <input type="checkbox"/> Evoke Chin
Applicator S/N: (Not applicable to RFAL HP)	Please indicate applicator name if multiple applicators have been used. Click here to enter text.			
Consumable: (For Morpheus8 only)	<input type="checkbox"/> 24P Regular <input type="checkbox"/> 24P Resurfacing <input type="checkbox"/> 12P Prime <input type="checkbox"/> 40P Body			
Consumable Lot Number: (Applicable to RFAL HP and Morpheus8 Tips only)	Click here to enter text.			
Complaint Description:	Click here to enter text.			