

FAX TO:

866-886-7736

RESEARCH PARTNER PROGRAM • FOLLOW-UP #1



Thanks for participating in our Research Partner Program! Your data will be used to document TheraTogs efficacy. Please fill out this form within 90 days of first issuing the TheraTogs system to your patient. If you have any questions, please contact us at 866-410-8062 or support@gaitways.com.

Clinician: _____

PT | OT | MD | CO | Orthotist | OTHER

Clinic/Facility: _____

City, State: _____

Email: _____

Phone: _____

PATIENT INFORMATION

Patient age & gender: _____ Years _____ Months Male Female Patient ID: _____

Patient Diagnosis: _____

ICD-9 Code(s) if any:

Prescribed wear schedule: All day Half-day Sessions only Other: _____

Duration of TheraTogs use: 1 week 1 month 3 months Other: _____

Primary TheraTogs objective: _____

Charted improvements (include any evidence): _____

Secondary TheraTogs objective: _____

Charted improvements (include any evidence): _____

TheraTogs helped me help this client achieve our therapy goals... No Yes

This client would NOT have made the same gains in this amount of time without TheraTogs... No Yes

Recent scores on any applicable standard Functional Assessment tests:

GMFM-88 _____ GMFM-66 _____ PEDI _____ AIM _____ Other: _____

Other clinical observations: _____

Patient/Caregiver compliance: _____
(Circle score) 1 2 3 4 5 6 7 8 9 10
Low High

Patient/Caregiver feedback: _____

Thanks for your time and information!

FAX TO:

RESEARCH PARTNER PROGRAM • FOLLOW-UP #2



866-886-7736

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Clinician: _____

PT | OT | MD | CO | Orthotist | OTHER

Clinic/Facility: _____

City, State: _____

Email: _____

Phone: _____

PATIENT INFORMATION

Patient age & gender: _____ Years _____ Months Male Female Patient ID: _____

Patient Diagnosis: _____

ICD-9 Code(s) if any:

Prescribed wear schedule: All day Half-day Sessions only Other: _____

Duration of TheraTogs use: 1 week 1 month 3 months Other: _____

Primary TheraTogs objective: _____

Charted improvements (include any evidence): _____

Secondary TheraTogs objective: _____

Charted improvements (include any evidence): _____

TheraTogs helped me help this client achieve our therapy goals... No Yes

This client would NOT have made the same gains in this amount of time without TheraTogs... No Yes

Recent scores on any applicable standard Functional Assessment tests:

GMFM-88 _____ GMFM-66 _____ PEDI _____ AIM _____ Other: _____

Other clinical observations: _____

Patient/Caregiver compliance: _____
(Circle score) 1 2 3 4 5 6 7 8 9 10
Low High

Patient/Caregiver feedback: _____

Thanks for your time and information!

FAX TO:

RESEARCH PARTNER PROGRAM • FOLLOW-UP #3



866-886-7736

Thanks for participating in our Research Partner Program! Your data will be used to document TheraTogs efficacy. Please fill out this form within 90 days of first issuing the TheraTogs system to your patient. If you have any questions, please contact us at 866-410-8062 or support@gaitways.com.

Clinician: _____

PT | OT | MD | CO | Orthotist | OTHER

Clinic/Facility: _____

City, State: _____

Email: _____

Phone: _____

PATIENT INFORMATION

Patient age & gender: _____ Years _____ Months Male Female Patient ID: _____

Patient Diagnosis: _____

ICD-9 Code(s) if any:

Prescribed wear schedule: All day Half-day Sessions only Other: _____

Duration of TheraTogs use: 1 week 1 month 3 months Other: _____

Primary TheraTogs objective: _____

Charted improvements (include any evidence): _____

Secondary TheraTogs objective: _____

Charted improvements (include any evidence): _____

TheraTogs helped me help this client achieve our therapy goals... No Yes

This client would NOT have made the same gains in this amount of time without TheraTogs... No Yes

Recent scores on any applicable standard Functional Assessment tests:

GMFM-88 _____ GMFM-66 _____ PEDI _____ AIM _____ Other: _____

Other clinical observations: _____

Patient/Caregiver compliance: _____
(Circle score) 1 2 3 4 5 6 7 8 9 10
Low High

Patient/Caregiver feedback: _____

Thanks for your time and information!