



MEDICAL RELEASE FORM

Using neuro-rehabilitation equipment, such as Galileo Neuromuscular Training Systems or a bionic exoskeleton suit, is a physical activity and involves a level of inherent risk and danger. Prior to taking part in Able Bionics USA programs, we require that each client have a physician's approval in order to ensure the safety of each individual.

The client's physician must sign this release before participating in Able Bionics USA programs.

Information Release

Dr. _____,

Please release the requested medical information regarding my condition to Able Bionics USA. This information will be used to help determine my eligibility to participate in Able Bionics USA's programs.

Client's Name (please print): _____

Client's Signature: _____

Client's Parent or Legal Guardian Signature: _____
(Necessary if client is under 18 years of age)

Date: _____

Physician's Name: _____

Type of practice: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____

Fax: _____

PERMISSION TO PARTICIPATE IN ABLE BIONICS USA PROGRAMS

Your patient has expressed interest in using neuro-rehabilitation equipment such as Galileo Neuromuscular Training Systems and bionic exoskeleton suits. A robotic human-assist exoskeleton is designed to be an ambulation device for individuals with impaired walking ability in the trunk and lower extremities due to spinal cord injury, a neurological disorder or disease.

Able Bionics USA requires your approval that **your patient is healthy enough to use Galileo Neuromuscular Training Systems (see contraindications list below), and weight bear on his/her legs, stand erect, and take assisted steps with a bionic exoskeleton suit.**

Before a Galileo training plan is established a good knowledge of the client's physical condition and possible risks must be assessed. The following contraindications must be excluded before the first use:

- Pregnancy
- Acute thrombosis (acute vascular constriction)
- Implants in trained regions of the body (e.g. artificial joints)
- Acute inflammation of the locomotor system active arthrosis or arthropathy (e.g. acute inflammation or swelling of joints)
- Acute tendinopathy in trained regions of the body (acute tendon inflammation)
- Acute hernia (soft tissue prolapse)
- Acute discopathy (acute problems at the intervertebral disc)
- Fresh fractures in trained regions of the body
- Gallstones or stones in the urinary tract collection system
- Post-surgery wounds and fresh wounds in trained regions of the body or incomplete wound healing
- Rheumatoid arthritis
- Epilepsy due to secondary risk of injury

There are NO contraindications using Galileo systems for training and treatment of patients with:

- Deep brain stimulator
- Pacemaker
- Internal defibrillators
- Spinal cord stimulators

Exoskeleton protocol for use is as follows:

- 1) A clinical exam to assess Range of Motion (ROM), strength, spasticity, proprioception and functional mobility.
- 2) Record anatomical measurements and fit a bionic exoskeleton device to the client
- 3) Assess fit of client in bionic exoskeleton device, checking ROM and all body contact points
- 4) Balance assessment (with spotters)
- 5) Ambulation with a FRW or Lofstrand crutches as indicated by balance (with spotters)
- 6) Ambulation with spotters using Lofstrand crutches with HMI if clinically indicated

Indications:

- 1) Sufficient ROM to tolerate sit to stand and normal walking ROM
- 2) Sufficient lower extremity bone density to stand and walk in standing frame or traditional orthotics
- 3) Sufficient upper extremity strength to assist with balance in standing with FRW and/or crutches
- 4) Sufficient orthostatic tolerance to tolerate upright for 15-30 minutes

Contraindications:

- 1) Poor standing tolerance
- 2) History of or concern regarding fractures with standing/weight bearing
- 3) Uncontrolled spasticity
- 4) Limited ROM that would prevent safe standing/walking
- 5) Insufficient upper extremity strength to assist with balance with FRW/Crutches



Your patient, _____, wishes to take part in Able Bionics USA programs, which may involve using a Galileo Neuromuscular Training System or a bionic exoskeleton suit.

Patient Information:

What is this patient's primary disability? _____

What is the cause of this disability? _____

Are there significant secondary disabilities? _____ () Yes () No

If yes, please describe: _____

Is this disability progressive? _____ () Yes () No

Does this patient use any of the following aids or assistive devices? (Please circle below)

Prosthesis Leg brace Wheelchair- manual Wheelchair- electric

Wrist brace Crutch/cane Walker

Other: _____

Are there any medical factors in your patient's history that would affect his or her ability to safely participate in this non-medically supervised program?

YES

NO

If yes, please list and explain: _____

Please identify any recommendations or restrictions that are appropriate for your patient: _____



Is this patient currently taking any medications that will affect activity?

YES

NO

If yes, please list and explain: _____

If you feel your patient meets the above criteria and is a safe candidate to use a Galileo Neuromuscular Training System or a bionic exoskeleton suit, please date and sign this form below.

My patient, _____, meets the above criteria and has my permission to take part in Able Bionics USA programs with the restrictions and/or recommendations stated above.

Physician name (please print): _____

Physician signature: _____

Date: ___/___/___