exogen®

PERFORMANCE PROGRAM

Performance Evaluation Form

Today's Date _____

Prescribing Physician Information

Prescribing Physician's Name _____

Hospital Name _____

Patient Information

Patient Initials _____

Fracture Diagnosis _____

Treatment Start Date _____

Date of Final Evaluation _____

EXOGEN Serial Number _____
(back of device)

Additional Information

I confirm that I have been treating the above patient for a bone fracture which showed no visibly progressive signs of healing (progression to bony union) after at least 120 days of consecutive EXOGEN treatment. I have made the evaluation based on X-rays taken prior to and after the patient's treatment with EXOGEN.

Must be signed by prescribing physician

Print _____

Signature _____ Date _____

Please print and sign document

Please complete, sign and return this form to:

Bioventus Coöperatief U.A.
Taurusavenue 31
2132 LS Hoofddorp
The Netherlands

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