



RETURN / COMPLAINT

This Return/Complaint form is sent to E-mail: info@decon.se. In case of potential serious incidents also send to vigilance@decon.se

1. The form will be registered at Decon and assigned a complaint number
2. If more information is needed, Decon will contact specified person
3. When returning a product: Attach a copy of this document to the shipment
4. Mark the shipment with "Complaint"
5. In case of failure of the main product, send complete device (all wheels, battery, cables, charger, etc.)
6. Feedback from Decon will come through order confirmation

Address for return;

Decon Wheel AB
Södra Ekeryd 119
SE-314 91 Hyltebruk, Sweden

Customer information. (Basis for confirmation of return)

Date:	Complaint number:
Customer nr:	Phone nr:
Customer name:	Mobile phone nr:
Contact:	E-mail address:
Address: (for possible pick-up and return, or if necessary for replacement product)	

Reason for return / complaint (to be filled out by Decon)

Complaints ()	Warranty matter ()	Accident/ Incident* ()	Incorrect ordering ()	Return test/loan ()	Repair ()
Other reason:					
The product shall be sent to Decon (need for consignment note) ()					
Decon's order number:	Customers order number:				

* In the event of a potential serious incident, move on to page 2.

Product information

Article number	Product name	Serial number*	Quantity	Delivery date

Which wheelchair is the product mounted on:

* In the event of a complaint about accessories or individual components, if possible, indicate the serial number of the main product.

Describe complaints

When did the event occur? (YYYYMMDD)	How many times has the product been reconditioned?
Describe the error, what has happened? What caused the problem and what were the related circumstances? (Feel free to attach photo.)	

Feedback/Action (Filled in by Decon)

Decon Wheel AB

Södra Ekeryd 119
SE-314 91 Hyltebruk, Sweden





For potential serious incidents (Send to vigilance@decon.se)

Product information

Article number	Medical device name	Serial number*	Quantity	Delivery date

Which wheelchair is the product mounted on:

* In the event of a complaint about accessories or individual components, if possible, indicate the serial number of the main product.

Provide a comprehensive description of the incident

When did the incident occur? (YYYYMMDD)	How many times has the product been reconditioned?
When did the manufacturer become aware of the incident? (YYYYMMDD)	
Describe what went wrong with the device, and a description of the health effects (if applicable), i.e. clinical signs, symptoms, conditions as well and the overall health impact (i.e. Death; life-threatening; hospitalization – initial or prolonged; required intervention to prevent permanent damage; disability or permanent damage; congenital anomaly/Birth defects; indirect harm; no serious outcome. (Feel free to attach photo.)	
What is the current location of the device (if known)?	
Operator of the device at the time of the incident (e.g. Healthcare professional, patient / user, other)?	
Was the device used for the first time? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Was any problem noted prior to use? Yes <input type="checkbox"/> No <input type="checkbox"/> , if yes describe the problem:	
Remedial actions taken by healthcare facility, patient or user subsequent to the incident?	

User Information

Number of users involved:	Gender and date of birth of user(s) at the time of the incident:
Body weight and height of the user(s):	
List any of the user(s)'s prior health conditions or medication that may be relevant to this incident (per user):	

Initial Reporter Information

Role of initial reporter (e.g., healthcare professional, Patient, User)	Name of facility where incident occurred:
Healthcare facility report number (if applicable)	Phone nr:
Contacts name:	E-mail address:
Address:	