



PLEASE FAX OR E-MAIL THIS REFERRAL FORM AND THE FOLLOWING TO (615) 807-3334 OR INFO@COMPRESSIONCARE.COM

- FACE SHEET INSURANCE CARD IMAGES PLAN OF CARE OFFICE NOTES ANY ADDITIONAL INSTRUCTIONS

PLEASE CALL OR TEXT (615) 583-2273 FOR IMMEDIATE ASSISTANCE COMPLETING THIS FORM

Rx & Certificate of Medical Necessity for LOWER EXTREMITY Compression Garments

PATIENT INFORMATION
Name, Address, City, State, Zip, Email, Date, Date of Birth, Diagnosis Code, Gender, Duration, Refills, Extremity

DAY GRADIENT COMPRESSION GARMENTS
Circular-Knit (mmHg): 15-20, 20-30, 30-40, 40-50
Flat-Knit (mmHg): 18-21, 23-32, 34-46, 50+
KNEE-HIGH, THIGH-HIGH, FULL WAIST options

GRADIENT COMPRESSION WRAPS—NON-ELASTIC SUPPORT GARMENT
Binder Garment with Adjustable Velcro Straps
GRADIENT NIGHT COMPRESSION GARMENT—NON-ELASTIC SUPPORT GARMENT
Night Garment with Foam Core / Channeled Style for Compression

OTHER GARMENTS
Description, Qty, Ready Made, Custom, Specifications

Treatment Plan: The treatment plan for this prescription is for compression garments to be worn during day and/or night on a daily basis as prescribed by the physician.

Certification of Medical Need: The medical equipment herein prescribed is medically necessary to heal and to prevent ulcers/wounds and to contain lymphedema, to prevent ulcers/infection/cellulitis and/or to decrease pain and/or to increase blood flow using gradient pressure.

PHYSICIAN AUTHORIZATION
Therapist Name / Facility, Phone / Fax, Therapist Email, Referring Physician Name, Phone / Fax, Address / City / State / Zip, Physician Signature, NPI, Date