

NPI

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

nx & certificate of incurcal necessity for Lowell Extraction 1 compression dufficities	
PATIENT INFORMATION	
Name	Phone
Address	
City	State Zip
Email	
Date	Date of Birth
Diagnosis Code	Gender
Duration 99 Months / Permanent Use Refills	Extremity
DAY GRADIENT COMPRESSION GARMENTS	
Circular-Knit (mmHg): ☐ 15-20 ☐ 20-30 ☐ 30-40 ☐ 40-50 ☐ Class 1 Class 2 Class 3	Flat-Knit (mmHg): □ 18-21 □ 23-32 □ 34-46 □ 50+ Class 1 Class 2 Class 3 Class 4
KNEE-HIGH □ Ready Made □ Ankle Relief □ □ Left, Qty: □ Right, Qty: □ Custom □ Other:	Silicone Border Slant Top
	Knee Relief Silicone Border Slant Top
	Closed Crotch Compressive Body
GRADIENT COMPRESSION WRAPS—NON-ELASTIC SUPPORT GARMENT OTHER GARMENTS	
Binder Garment with Adjustable Velcro	Straps
☐ Left ☐ Ready Made ☐ Foot, Qty: ☐ ☐ Calf, Qty: ☐ ☐ Knee, Qty: ☐ Foot + Calf, Qty: ☐ ☐ Foot + Calf + Knee, Qty: ☐ ☐ Other: ☐ ☐ Other: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
GRADIENT NIGHT COMPRESSION GARMENT—NON-E	ELASTIC SUPPORT GARMENT Ready Made
Night Garment with Foam Core / Channeled Style	
☐ Left ☐ Ready Made ☐ Knee-High, Qty: ☐ Thigh-High, Qty: ☐ Outer Jacket ☐ Variable Compression Jacket ☐ Other:	Full Waist, Qty: Other, Qty: 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	

Date