COMPRESSION CARE

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 UPPER EXTREMITY Compression Garments

PATIENT INFORMATION

Name		Phone	
Address			
City		State	Zip
Email			
Date		Date of Birth	
Diagnosis Code		Gender	
Duration **99 Months / Permanent Use**	Refills	Extremity ☐ Left ☐ Right ☐ Bilateral	

DAY GRADIENT COMPRESSION GARMENTS

Circular-Knit (mmHg): ☐ 15-20 Class 1 ☐ 20-30 Class 2 ☐ 30-40

Flat-Knit (mmHg): ☐ 18-21 Class 1 ☐ 23-32 Class 2 ☐ 34-46 Class 3

ARM SLEEVE ☐ Left, Qty: _____ ☐ Right, Qty: _____	☐ Ready Made ☐ Custom ☐ Silver	☐ Silicone Border (☐ 3cm or ☐ 5cm) ☐ Elbow Dart ☐ Comfort Patch ☐ Slant Top ☐ Other: _____ Color(s): _____
HAND PIECE ☐ **Full Finger (ACFS)** ☐ **Gauntlet Only (AC)** ☐ Left, Qty: _____ ☐ Right, Qty: _____	☐ Ready Made ☐ Custom ☐ Silver	☐ Dorsal Pocket/Pad ☐ Comfort Patch at Thumb ☐ Wrist Extension ☐ Other: _____ Color(s): _____
TRUNCAL GARMENT ☐ Left ☐ Right	☐ Ready Made ☐ Custom	☐ **Compression Bra, Qty: _____** ☐ **Compression Tank/Cami, Qty: _____** ☐ **Compression T-Shirt, Qty: _____** ☐ **Full Vest, Qty: _____** ☐ Other: _____ _____

GRADIENT NIGHT COMPRESSION GARMENT—NON-ELASTIC SUPPORT GARMENT

Night Garment with Foam Core / Channeled Style for Compression

☐ Left ☐ Right	☐ Ready Made ☐ Custom	☐ **Arm Sleeve, Qty: _____** ☐ **Glove, Qty: _____** ☐ **1-Piece Sleeve/Glove Combination, Qty: _____** ☐ Outer Jacket (Adds 10-15 mmHg) ☐ Variable Compression Jacket (20-40 mmHg)

OTHER GARMENTS

☐ Left ☐ Right	☐ Ready Made ☐ Custom	☐ Description: _____, Qty: _____ ☐ Other: _____

VELCRO WRAPS

☐ **Arm Sleeve**

Qty: _____

☐ **Hand Piece**

Qty: _____

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