COMPRESSION CARE

PLEASE FAX OR E-MAIL THIS CLINICAL RESPONSE FORM TO (615) 807-3334 OR REFERRALS@COMPRESSIONCARE.COM
PLEASE CALL OR TEXT (615) 583-2273 FOR IMMEDIATE ASSISTANCE COMPLETING THIS FORM

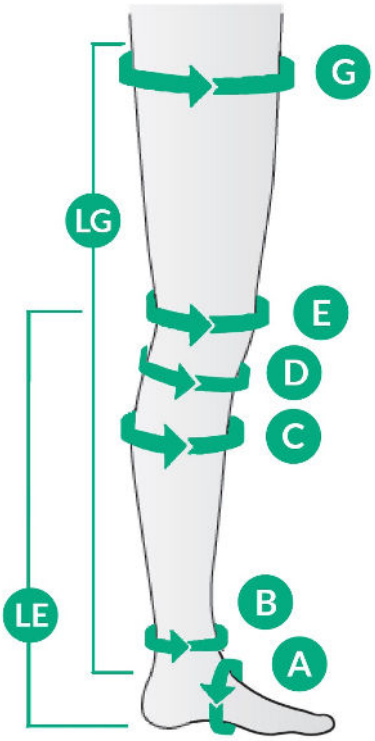
Rx & Certificate of Medical Necessity for Compression Garments

PATIENT INFORMATION

Name	Phone	
Address		
City	State	Zip
Email		
Date of Birth	Duration **Lifetime/Purchase** ☐ Other _____	
Check All Affected Areas ☐ Foot ☐ Ankle ☐ Calf ☐ Knee ☐ Thigh ☐ Full Leg ☐ Other _____		
Garments ☐ Left ☐ Right ☐ Bilateral	Compression (mmHg) LT: ☐ 18-30 ☐ 30-40 ☐ >40 RT: ☐ 18-30 ☐ 30-40 ☐ >40	
☐ Please check to confirm this patient is NOT currently in-patient in a hospital or managed care facility, AND is NOT currently in a home health managed care episode.		

DIAGNOSIS CODE—CHECK ALL THAT APPLY

☐ Q82.0 Primary Lymphedema ☐ I89.0 Secondary Lymphedema DUE TO (Required) _____
☐ I97.2 Post Mastectomy Lymphedema ☐ I97.89 Postprocedural Complications and Disorders of the Circulatory System _____



MEASUREMENTS (CM)

	Left	Right
(A) Mid Foot		
(B) Ankle		
(C) Widest Calf		
(D) Below Knee		
(E) Patella		
(LE) E to Floor		
(LG) G to Floor		

GARMENTS & QUANTITY

Knee High	Left	Right
☐ Lower Leg Wrap (Light)	3	3
☐ Knee High Circular Knit Stocking	3	3
☐ Lower Leg Wrap (Heavy)	3	3
☐ Nighttime Compression Garment	2	2
Thigh High / Foot Piece	Left	Right
☐ Full Leg Wrap	3	3
☐ Thigh High Circular Knit Stocking	3	3
☐ Ankle Foot Wrap	3	3

Notes

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