



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 <input type="checkbox"/> Lifetime/Purchase <input type="checkbox"/> Other _____	
Check All Affected Areas <input type="checkbox"/> Foot <input type="checkbox"/> Ankle <input type="checkbox"/> Calf <input type="checkbox"/> Knee <input type="checkbox"/> Thigh <input type="checkbox"/> Full Leg <input type="checkbox"/> Other _____			
Garments <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral		Compression (mmHg) LT: <input type="checkbox"/> 18-30 <input type="checkbox"/> 30-40 <input type="checkbox"/> >40 RT: <input type="checkbox"/> 18-30 <input type="checkbox"/> 30-40 <input type="checkbox"/> >40	
<input type="checkbox"/> 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

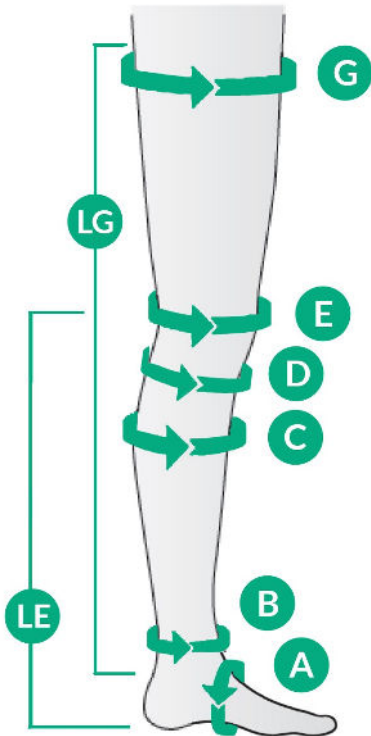
Knee High

- Juzo Velcro Wrap w/ Liner
 Juzo Dynamic
 Juzo Nighttime Wrap

Thigh High / Foot Piece

- Juzo Velcro Wrap w/ Liner
 Juzo Dynamic
 Juzo Knee Wrap
 Juzo Compression Foot Wrap

	Left	Right
	3	3
	3	3
	2	2
Left	Right	
	3	3
	3	3
	3	3
	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	