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 LOWER 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 Class 3 ☐ 40-50

Flat-Knit (mmHg): ☐ 18-21 Class 1 ☐ 23-32 Class 2 ☐ 34-46 Class 3 ☐ 50+ Class 4

KNEE-HIGH ☐ Left, Qty: _____ ☐ Right, Qty: _____	☐ Ready Made ☐ Custom	☐ Ankle Relief ☐ Silicone Border ☐ Slant Top ☐ Other: _____
THIGH-HIGH ☐ Left, Qty: _____ ☐ Right, Qty: _____	☐ Ready Made ☐ Custom	☐ Ankle Relief ☐ Knee Relief ☐ Silicone Border ☐ Slant Top ☐ Other: _____
FULL WAIST ☐ Qty: _____	☐ Ready Made ☐ Custom	☐ Open Crotch ☐ Closed Crotch ☐ Compressive Body ☐ Other: _____

GRADIENT COMPRESSION WRAPS NON ELASTIC SUPPORT GARMENT

Binder Garment with Adjustable Velcro Straps

☐ Left ☐ Right	☐ Ready Made ☐ Custom	☐ **Foot, Qty: _____** ☐ **Calf, Qty: _____** ☐ **Knee, Qty: _____** ☐ **Thigh, Qty: _____** ☐ **Foot + Calf, Qty: _____** ☐ **Foot + Calf + Knee, Qty: _____** ☐ **Foot + Calf + Knee + Thigh, Qty: _____** ☐ Other: _____

GRADIENT NIGHT COMPRESSION GARMENT NON ELASTIC SUPPORT GARMENT

Night Garment with Foam Core / Channeled Style for Compression

☐ Left ☐ Right	☐ Ready Made ☐ Custom	☐ **Knee-High, Qty: _____** ☐ **Thigh-High, Qty: _____** ☐ **Full Waist, Qty: _____** ☐ **Other, Qty: _____** ☐ Outer Jacket ☐ Variable Compression Jacket ☐ Other: _____

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