



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 ☐ 20-30 ☐ 30-40 ☐ 40-50		Flat-Knit (mmHg): ☐ 18-21 ☐ 23-32 ☐ 34-46 ☐ 50+	
Class 1 Class 2 Class 3		Class 1 Class 2 Class 3 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. Fitter to determine quantities, models, and manufacturers as medically necessary for patient use, lifestyle, and mobility unless otherwise specified. Fitter to accessorize as medically necessary for best patient efficacy.

PHYSICIAN AUTHORIZATION

Therapist Name / Facility		Phone / Fax	
Therapist Email			
Referring Physician Name		Phone / Fax	
Address / City / State / Zip			
► Physician Signature			
NPI		Date	