Fax to: 516-452-5095 or
Email to: medical records@aa-medsupply.com

"Suppliers of Non-Custom Medical Compression Garments"

Medical Compression Prescription Form

Patient Name:_____________________________________ **DOB:**_____/_____/_________

Diagnosis (ICD-10): ☐ I87.2 Venous Insufficiency ☐ I83.323 Venous Hypertension . ocali ed dema
I8 . ymp edema I73. Perip eral Vascular isease 8 .7 8 History of t er V m olism
I83.8 3 Varicose Veins of Pain [illegible]
[illegible]

☐]] ☐]]

Compression: ☐ 15-20 mmHg (Retail Only) ☐ 20-30 mmHg ☐ 30-40 mmHg ☐ [illegible]

[illegible]




☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible]




☐ Inelastic Compression Wraps ☐ [illegible] ☐ Compresssion Gauntlet ☐ Compression Glove

Quantity: Number of Pairs___________ Number of Refills ___________ ☐ 3 Month Supply

☐ Closed Toe ☐ Open Toe ☐ [illegible] ☐ Left [illegible]

Additional Comments:

____

Physician Name: ____ **NPI:** _________________________

Physician Phone Number: ___________________________________

Physician's Signature: ______________________________________ **Date:** ______/______/_________

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https://www.allamericanmedsupply.com/compressiongarments