

Standard Written Order - Medical Compression

1 PATIENT INFORMATION

Patient Name: _____ Order Date: ____/____/____
 Patient Phone: (____) ____ - _____ Date of Birth: ____/____/____

2 DIAGNOSIS

- | | | |
|---|--|--|
| <input type="checkbox"/> I87.2 Venous insufficiency | <input type="checkbox"/> I87.323 Venous hypertension | <input type="checkbox"/> I83.811 Varicose veins of RLE with pain |
| <input type="checkbox"/> I89.0 Lymphedema | <input type="checkbox"/> I73.9 Peripheral vascular disease | <input type="checkbox"/> I83.812 Varicose veins of LLE with pain |
| <input type="checkbox"/> Q82.0 Hereditary lymphedema | <input type="checkbox"/> R60.0 Localized edema | <input type="checkbox"/> I83.813 Varicose veins of BLE with pain |
| <input type="checkbox"/> I97.2 Post-mastectomy syndrome | <input type="checkbox"/> Z86.718 History of other DVT/embolism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> I97.9 Other postprocedural complications and disorders of the circulatory system, not elsewhere classified | | |

3 COMPRESSION LEVEL

20-30 mmHg 30-40 mmHg 40-50 mmHg _____ mmHg

4 PRODUCT

Lower Extremity Garments

- Knee High
- Thigh High
- Thigh High (Chaps Style)
- Waist High/Pantyhose
- Compression Shorts
- Open Toe Closed Toe

Quantity:

Number of Units: _____

Refills: _____

- 3-Month Supply
- 6-Month Supply (Medicare)
- Bilateral Right Left

Upper Extremity Garments

- Arm Sleeve with Silicone Band
- Arm Sleeve without Silicone Band
- Gauntlet
- Glove
- Head/Neck

Quantity:

Number of Units: _____

Refills: _____

- 3-Month Supply
- 6-Month Supply (Medicare)
- Bilateral Right Left

Inelastic Velcro Wraps

- Calf (ankle to below knee)
- Full Leg (ankle to thigh)
- Foot (foot to ankle)
- Toe Caps
- Knee (knee only)
- Thigh (above knee to thigh)
- Arm (wrist to axilla)
- Accessory Liners LE, BK or Full Leg

Quantity:

Number of Units: _____

Refills: _____

- 3-Month Supply
- 6-Month Supply (Medicare)
- Bilateral Right Left

Nighttime Garments

Medicare allows two night garments per limb every two years.

- Upper Extremity – Arm
- Upper Extremity – Hand
- Upper Extremity – Arm/Hand
- Lower Leg and Foot
- Full Leg and Foot
- Nighttime Bra

Quantity:

Number of Units: _____

- Bilateral Right Left

5 ADDITIONAL COMMENTS

6 Provider's Name: _____ NPI: _____
 Provider's Phone Number: (____) ____ - _____
 Provider's Signature: _____ Date: ____/____/____