"Specializing in Ready-to-Wear Compression Garments"

Fax to: 516-452-5095 *or*
Email to: medicalrecords@aa-medsupply.com

Standard Written Order - Medical Compression

Order Date: _____/_____/________

Patient Name: ____________________________________ DOB:_____/_____/________

Diagnosis:

☐ I87.2 Venous Insufficiency ☐ I83.323 Venous Hypertension ☐ R60.0 Localized Edema
☐ I89.0 Lymphedema ☐ I73.9 Peripheral Vascular Disease ☐ Z86.718 History of Other DVT / Embolism
☐ I83.811 Varicose Veins of RLE w/Pain ☐ I83.812 Varicose Veins of LLE w/ Pain
☐ I83.813 Varicose Veins of BLE w/ Pain ☐ I83.893 Varicose Veins of BLE w/ Other Complications
☐ Q82.0 Herediary Lymphedema ☐ I 97.2 Post Mastectomy Syndrome ☐ ______________________________

Compression Level:

☐ 15-20 mmHg (Retail Only) ☐ 18-30 mmHg ☐ 30-40 mmHg ☐ 40-50 mmHg ☐ ________ mmHg

Style:

☐ Knee High ☐ Thigh High ☐ Waist High / Pantyhose ☐ Thigh High w/Waist Attachment
☐ Maternity Waist High ☐ Armsleeve ☐ Gauntlet ☐ Glove
☐ Inelastic Wraps
☐ Calf (30-50 mmHg) for Medicare/Lymphedema ☐ Foot ☐ Thigh ☐ Arm Wraps

☐ Closed Toe ☐ Open Toe ☐ Right ☐ Left ☐ Silicone Grip Top

Quantity:

*Please document in your chart note, the type and strength of the stocking being ordered.
*Please note that when ordering compression garments, 1 Unit (Ea) = 1 Sock , 2 Units = 1 pair of socks

Number of Units__________ Number of Refills __________ ☐ 3 Month Supply

Additional Comments: ____

____

Physician's Name: ____ NPI: __________________________

Physician's Phone Number: ____________________________________

Physician’s Signature: ____ Date: ______/______/_________