ALL AMERICAN
Medical Supply Corp.

Specializing in Ready-to-Wear Compression Garments

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

Standard Written Order - Medical Compression

1 Order Date:_____/_____/_____ Patient Name: _____

Patient Phone: (_____) _____-_____ Date of Birth: _____ /_____ /_____

2 ## DIAGNOSIS

- ☐ I87.2 Venous Insufficiency
- ☐ I87.323 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 Hereditary Lymphedema
- ☐ I 97.2 Post Mastectomy Syndrome
- ☐ _____

3 ## COMPRESSION LEVEL

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

4

Lower Extremity

- ☐ Knee High
- ☐ Thigh High
- ☐ Thigh High (Chaps Style)
- ☐ Waist High/ Pantyhose
- ☐ Maternity Pantyhose
- ☐ Open Toe ☐ Closed Toe

Quantity:

Number of Units: _____

Refills: _____

- ☐ 3 Month Supply
- ☐ Bilateral ☐ Right ☐ Left

Upper Extremity

- ☐ Arm Sleeve w/Silicone Band
- ☐ Arm Sleeve w/o Silicone Band
- ☐ Gauntlet
- ☐ Glove

Quantity:

Number of Units: _____

Refills: _____

- ☐ 3 Month Supply
- ☐ Bilateral ☐ Right ☐ Left

Inelastic Wraps

- ☐ Calf (Ankle to below Knee)
- ☐ Foot (Foot to Ankle)
- ☐ Thigh (Above Knee to Thigh)
- ☐ Full Leg (Ankle to Thigh)
- ☐ Arm (Wrist to Axilla)

Quantity:

Number of Units: _____

Refills: _____

- ☐ 3 Month Supply
- ☐ Bilateral ☐ Right ☐ Left

Nighttime Garments

Medicare allows 2 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
- ☐ Cover for night garment

Quantity:

Number of Units: _____

- ☐ Bilateral ☐ Right ☐ Left

5 ## ADDITIONAL COMMENTS _____

6 Physician's Name: _____ NPI: _____

Physician's Phone Number: (_____) _____-_____

Physician's Signature: _____ Date: _____/_____/_____