COMPRESSION GARMENTS ORDER FORM

FAX ORDERS TO: 866-799-6863

EMAIL ORDERS TO: FAX@LYMPHACARE.COM

LymphaCare

Patient Name: _____ **DOB:** _____ **Height:** _____ **Weight:** _____

Address: _____ **Phone:** _____

Cell Number: _____ **Email Address:** _____

***** PLEASE SEND PATIENT DEMOGRAPHIC SHEET *****

Primary Insurance: _____ **ID #** _____ **Group #** _____

Secondary Insurance: _____ **ID #** _____ **Group #** _____

DIAGNOSIS ☐ Q82.0 Primary Lymphedema ☐ I89.0 Secondary Lymphedema/NEC
☐ I97.2 Post Mastectomy Lymphedema ☐ I97.89 Other Postprocedural Complications of the Circulatory System, NEC

DAY

TYPE ☐ Elastic (stockings) ☐ Inelastic (wraps/banding, eg Circaid) | ☐ Right ☐ Left ☐ Bilateral
COMPRESSION LEVEL ☐ 20-30 mmHg ☐ 30-40 mmHg ☐ 40-50 mmHg
LOWER EXTREMITY STYLE ☐ Knee High ☐ Thigh High ☐ Panty **TOE STYLE** ☐ Open ☐ Closed
UPPER EXTREMITY STYLE ☐ Sleeve ☐ Glove ☐ Gauntlet
QUANTITY ☐ 6 per affected limb/year ☐ Other: _____ **COLOR** ☐ Black ☐ Beige

NIGHT

STYLE ☐ Arm ☐ Arm w/Hand ☐ Full Leg ☐ Half Leg | ☐ Right ☐ Left ☐ Bilateral
QUANTITY ☐ 2 per affected limb/2 years ☐ Other: _____

Brand: ☐ Sigvaris ☐ Juzo ☐ Medi ☐ Other: _____

Measurements Required (centimeters)

LOWER EXTREMITY

		RIGHT	LEFT
Circumference	Ankle:		
	Calf:		
	Thigh:		
	Waist:		
Length to Floor	Knee Fold:		
	Mid-Thigh:		
	Waist:		

UPPER EXTEMITY

		RIGHT	LEFT
Circumference	Upper Arm:		
	Elbow:		
	Mid-Forearm:		
	Wrist:		
	Metacarpus:		
Length	Axilla to Wrist:		
	Wrist to MCP:		
	MCP to Distal:		

Notes (callouts or style specifications): _____

The above compression garments are medically necessary for the treatment of this patient's lymphedema.

_____ _____ _____
Signature Date NPI

_____ _____
Prescriber (printed name) Office Contact Name & Phone