PERIPHERAL ARTERY DISEASE PUMP

FAX ORDERS TO: 866-799-6863

EMAIL ORDERS TO: FAX@LYMPHACARE.COM

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

Address: _____ **Phone:** _____

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

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

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

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

Office Contact Name: _____ **Ph#:** _____ **Email:** _____

DIAGNOSIS ☐ I73.9 Peripheral Vascular Disease, Unspecified ☐ Other: _____

INDICATIONS ☐ Ulcer(s) ☐ Ischemia ☐ Angioplasty/Stent Failure ☐ Arteriopathic Wound ☐ Graft Failure ☐ Minor Amputation (specify: _____) ☐ Intermittent Claudication ☐ Rest Pain ☐ Night Pain

PAD Pump (E0675) ORDER

Sizing (choose)

	Arch/Instep	Mid Calf	Upper Calf
☐ **Narrow**	5"-10"/13-25 cm	6.5"-15"/16-38 cm	7.5"-17.5"/19-44 cm
☐ **Standard**	8"-12.5"/20-32 cm	9.5"-18"/24-46 cm	10.5"-20.5"/27-52 cm
☐ **Wide**	8"-14.5"/20-37 cm	11"-25"/28-63 cm	12"-27.5"/30-70 cm

Specifics

Compression Level	☐ 120 mmHg	☐ Other: _____
Session Length	☐ 1 hour	☐ Other: _____
Frequency	☐ 2x Daily	☐ Other: _____

Please include recent medical records that reference the patient's condition and diagnosis, along with the need for this peripheral arterial pump, with this order submission.

The above ordered compression device is medically necessary for treatment of the patient's peripheral arterial disease.

_____ _____

Signature Date

_____ _____

Prescriber (printed name) NPI