

# Physician's Prescription for Medical Compression Garments

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_ Patient Address: \_\_\_\_\_

Diagnosis:  I87.2 - Venous insufficiency  R60.0 - Edema  I83.10 - Varicose Veins  
 Other \_\_\_\_\_

Extremity:  Left  Right  Pair Quantity: \_\_\_\_\_

*This product is a medical necessity and requires a diagnosis for insurance reimbursement.*

COMPRESSION	
<input type="checkbox"/> <b>Support 15-20 mmHg</b>	Aching/fatigued legs, mild ankle and foot edema, mild varicosities, prophylaxis during pregnancy, post sclerotherapy
<input type="checkbox"/> <b>20-30 mmHg</b>	Aching/fatigued legs, mild venous insufficiency, prophylaxis during pregnancy, moderate varicosities, hereditary tendency toward varicose veins, post sclerotherapy, mild edema or lymphedema, burn scar management, hypertrophic scar treatment, prevention of venous ulcers, in conjunction with the management of open venous ulcers, DVT prevention, superficial thrombophlebitis
<input type="checkbox"/> <b>30-40 mmHg</b>	Chronic venous insufficiency, severe varicosities, post surgical, moderate and post traumatic edema, post phlebectomy, post sclerotherapy, pronounced varicosities during pregnancy, orthostatic hypotension, moderate lymphedema, prevention of venous ulcers, in conjunction with the management of open venous ulcers, burn scar management, DVT/post thrombotic syndrome
<input type="checkbox"/> <b>40-50 mmHg</b>	Severe tendencies toward edema, severe lymphedema, severe chronic venous insufficiency, in conjunction with the management of open venous ulcers
<input type="checkbox"/> <b>50+ mmHg</b>	Severe post thrombotic conditions, severe lymphedema, elephantiasis
CONTRAINDICATIONS	Untreated open venous ulcers, intermittent claudication, acute thrombophlebitis, phlebothrombosis, arterial disease, uncontrolled congestive heart failure, acute dermatitis, weeping dermatosis

STYLE	
<input type="checkbox"/> <b>Open Toe</b>	<input type="checkbox"/> Knee-High <input type="checkbox"/> Thigh-High <input type="checkbox"/> Thigh-High with Hip Attachment <input type="checkbox"/> Pantyhose <input type="checkbox"/> Maternity Pantyhose <input type="checkbox"/> Arm Sleeve <input type="checkbox"/> Hand Gauntlet
<input type="checkbox"/> <b>Closed Toe</b>	

Physician's Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

Date: \_\_\_\_\_

*Dispense as written*

**FAX TO: 866-509-3169**