FAX 866-984-3831

MEDICAL COMPRESSION GARMENT PRESCRIPTION

.

Patient Name:_____ Phone: _____

Diagnosis:_____ DOB: _____

Fitting your patient with the right garment is our specialty. Do you have a style in mind? **Indicate below**:

- ○ Knee high
- ○ Thigh high
- ○ Pantyhose
- ○ Biker short
- ○ Arm sleeve
- ○ Glove/Guantlet
- ○ Shirt/Tank/Bra
- ○ Head/Neck

- ○ Other:_____

Indicate Compression Level:

COMPRESSION LEVEL	INDICATION
○ **15-20mmHG**	**Preventative compression or fragile skin**
○ **20-30mmHG**	**Mild varicosities, mild venous insufficiency or Stage 1-2 lymphedema**
○ **30-40mmHG**	**Moderate varicosities, moderate venous insufficiency, stage 2-3 lymphedema**

Anything you would like us to know to better serve your patient?

_____

_____

_____

Prescriber's name: _____

Prescriber's signature:_____ **Date:**_____

4918 Temple Ave, Suite F Evansville IN 47715
P: 812-303-3831 F: 866-984-3831
BY APPOINTMENT ONLY