

JOBST® Custom Seamed

VEST FORM (No Bra Cups)



an Essity company

Date: _____ Fitter.: _____

Patient Name or ID #: _____ Date of Birth: _____ / _____ / _____
Month Year

Address _____

Phone: _____ Fax: _____ E-mail*: _____

Clinic Name: _____

Ship To : _____

DIAGNOSIS: Please Check Appropriate Box(es)

- | | | | |
|--|--|---|---------------------------------|
| <input type="checkbox"/> Edema | <input type="checkbox"/> Thrombotic Syndrome | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Sclerotherapy / Vein Ligation | <input type="checkbox"/> Venous Insufficiency | _____ |
| <input type="checkbox"/> Orthostatic Hypotension | <input type="checkbox"/> Venous Ulcer | <input type="checkbox"/> Arterial Insufficiency | Prescribed pressure: |
| | | | _____ |

1. STYLE			
CAT #		QTY	PRICE
100525	SLEEVELESS VEST		
100524	VEST - 1 LONG SLEEVE, 1 SHORT SLEEVE		
100526	VEST - 2 SHORT SLEEVES		
100527	VEST - 2 LONG SLEEVES		

2. OPTIONS			
CAT #		QTY	PRICE
100150	BEIGE		N/A
100158	BLACK		N/A
100160	2" SILICONE BAND		

3. DESIGN CHOICES		
	YES	NO
FRONT ZIPPER		
HOOK & EYE (2 SETS) BEHIND ZIPPER		
V-NECK		



Questions? Call 888-358-1580.

Fax or Email this form to

443-455-1402 or

Orders@comfortcaremd.com

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4. BODY MEASUREMENTS

	CIRCUM	LENGTH
LEFT SHOULDER		N/A
RIGHT SHOULDER		N/A
NECK		N/A
CHEST		N/A
SHOULDER WIDTH	N/A	
SHOULDER TO WAIST	N/A	
CIRCUMFERENCE AT WAIST		N/A
SHOULDER TO END OF SUPPORT	N/A	
CIRCUMFERENCE AT END OF SUPPORT		N/A

Please note:

This side of form must be submitted with front side.

5. ARM MEASUREMENTS

WRIST PLEAT	LEFT		TAPE #	RIGHT		WRIST PLEAT
			-6			
			-4 ½			
			-3			
			-1½			
			0			
			+1½			
			+3			
			+4½			
			+6			
			+7½			
			+9 ELBOW			
			+10½			
			+12			
			+13½			
			+15			
			+16½			
AXILLA PLEAT			+18			AXILLA PLEAT
			+19½			

