Daytime Upper Extremity Order Form

(P) 888-385-1580
(F) 443-455-1402
(E) Orders@comfortcaremd.com

PATIENT INFORMATION

Name: ________ Phone Number: ________

Therapist /Fitter: ________ Clinic Name ________

Email: ________ Measurement Date: ________

GARMENT

Style PD - UE - ________

☐ Left Arm ☐ Right Arm

☐ Thumb Slit ☐ Full Thumb C= ________

Compression

☐ 20-30 mmHg ☐ 30-40 mmHg

☐ Other ________

Modifications

Placement Instruction

☐ No Silicone ☐ 1/2 Silicone ☐ Silicone

☐ Zippers ________

BILLING INFORMATION

☐ Quote Only

SHIPPING INFORMATION

Shipping:

Requested Delivery Date: ________

☐ Standard ☐ Priority

Ship to: ________

Attn: ________

Street: ________

City: ________ State: ____ Zip: ________

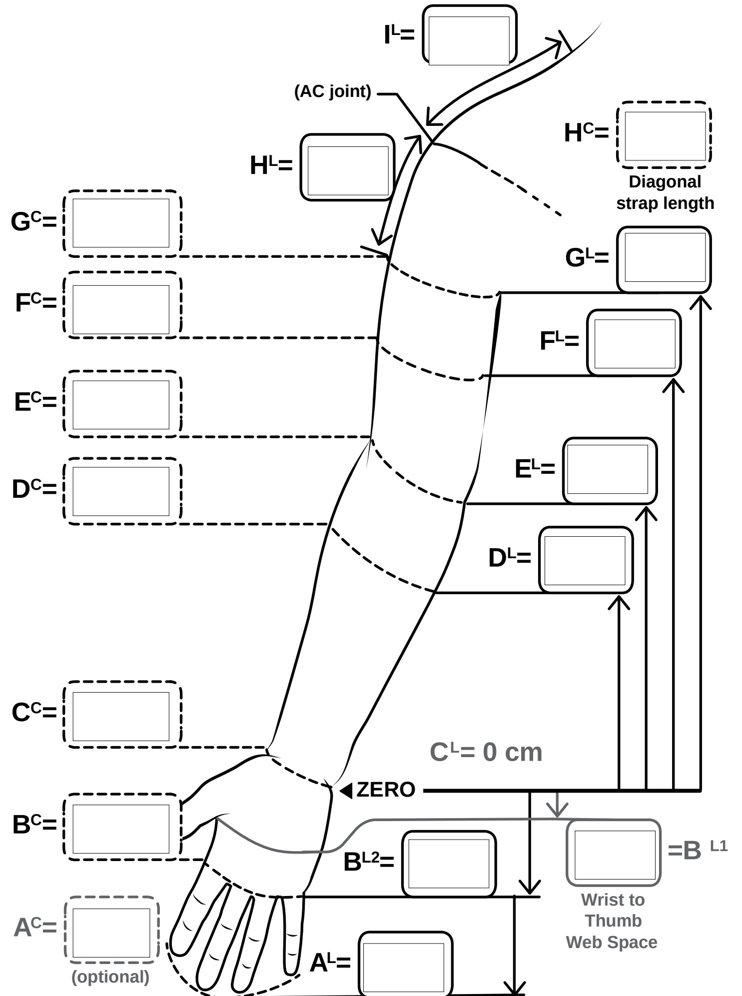
Phone: ________

Email: ________

(for shipping notification)

MEASUREMENTS

(All measurements in centimeters)



Notes:

Questions? Call 888-385-1580.

Fax or Email this form to 443-455-1402 or Orders@comfortcaremd.com

V 2024.06