

Measuring Charts & Ordering Guide

Care you deserve,
compression you need.

Comfort Care Medical

The Nation's #1
Lymphedema Compression, Mastectomy, & Wound Care Specialists

2026 Measuring Charts & Ordering Guide
For referring therapists & clinics

MEASURING CHARTS & ORDER FORMS INSIDE FROM

medi · JOBST · LR Compression · Juzo · sigvaris · THUASNE

May We Take Your Order?

To place an order, call, fax, or email us at:

888.358.1580

443.455.1402 fax
orders@comfortcaremd.com

comfortcaremd.com

Comfort Care Medical

Therapist Ordering Guide

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The Nation's #1
Lymphedema Compression, Mastectomy, & Wound Care Specialists

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Comfort Care Medical

Making The Ordering Process Easy As...

Follow This Simple Recipe and Enjoy Some Comfort!



The Nation's #1
Lymphedema Compression, Mastectomy, & Wound Care Specialists

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1 Send us the referral.

Fax or email the patient's demographics and insurance card, your clinical evaluation, and the measuring / order form. Already have a physician-signed prescription? Include it — it speeds things up. If not, skip it; that's our job.

Need documentation guidance? Medical necessity & custom-garment justification: **pages 4–6**. Prescription / Rx templates: **pages 13–15**.

2 Have the patient sign two forms.

The Consent and Notice of Privacy Practices (**pages 8–10**), ideally at the appointment. Let the patient know a delivery ticket will follow once their garment arrives — that signature sets the date of service.

Didn't get to it? No problem — we'll send both forms to the patient for e-signature, or mail them if we have no email on file.

3 That's it. We take it from here.

You'll hear back within 8 business hours with coverage details and the patient's estimated cost — and, where the plan allows, product options that maximize their benefit. We obtain the prescription and physician notes, collect the patient's portion, place and ship the order, send the delivery ticket, bill insurance, and handle authorizations, appeals, alterations and replacements.

Track any referral at portal.comfortcaremd.com — real-time status, one-click update requests.

May We Take Your Order?

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443.455.1402 fax
orders@comfortcaremd.com
comfortcaremd.com

Comfort Care Medical



We Work With Your Patients' Insurance

So You Can Focus on Their Care.

Hundreds of insurance plans nationwide — here are just some of the carriers we work with.

1 Insurance We Work With

HMO · PPO · POS · EPO · Exchange · Medicare Advantage · Federal Employee (FEHB) · BlueCard® — in-network with 60+ plans

MEDICARE & GOVERNMENT

- Medicare
- Medicare Advantage Plans
- TRICARE East
- TRICARE West
- TRICARE For Life
- CHAMPVA
- VA Community Care Network
- US Family Health Plan
- GEHA
- Mail Handlers Benefit Plan
- NALC Health Benefit Plan
- SAMBA
- Kaiser Federal & Postal Plans

MEDICAID

- Maryland Medical Assistance
- Connecticut Medicaid (HUSKY)
- Priority Partners
- Maryland Physicians Care
- MedStar Family Choice
- Aetna Better Health Maryland
- UHC Community Plan
- Wellpoint Maryland Medicaid
- Kaiser Permanente Medicaid

BLUE CROSS BLUE SHIELD

- Anthem BCBS Connecticut Plans
- Anthem Blue Cross CA Plans
- Highmark Pennsylvania Plans
- Highmark Delaware Plans
- Highmark West Virginia Plans
- Independence Blue Cross Plans
- Keystone Health Plan East Plans
- Personal Choice® Plans
- Keystone 65 Plans
- Personal Choice 65 Plans
- AmeriHealth Pennsylvania Plans
- AmeriHealth New Jersey Plans
- Capital BlueCross Plans
- BCBS of Michigan Plans
- BCBS of Vermont Plans
- The Vermont Health Plan
- Horizon BCBS New Jersey Plans
- First Priority Health Plans
- Blue Cross Northeastern PA Plans
- BCBS Federal Employee Plans
- BlueCard® Out-of-Area Plans

COMMERCIAL & MEDICARE ADVANTAGE

- Aetna Plans
- Aetna Medicare Advantage Plans
- Innovation Health Plans
- UnitedHealthcare Plans
- UHC Choice Plus Plans
- UHC Medicare Advantage Plans
- AARP Medicare Advantage Plans
- UMR Plans
- OneNet PPO Plans
- Humana Plans
- Humana Medicare Advantage Plans
- Cigna Healthcare Plans
- Cigna Great-West Plans
- Kaiser Permanente Plans
- Kaiser Medicare Advantage Plans
- Johns Hopkins EHP Plans
- Hopkins Health Advantage Plans
- MedStar Medicare Choice Plans
- Wellpoint Medicare Advantage Plans
- ConnectiCare Plans
- EmblemHealth Plans
- Workers Comp Plans

…and many more! This list isn't all-inclusive — we add new plans and contracts all the time, and we can often work with out-of-network benefits too. Not sure about a plan? Email **a.sakowski@comfortcaremd.com** and we'll verify it before the appointment.

THERAPIST PORTAL

portal.comfortcaremd.com

Track every referral in one place. See real-time order status, your full case load, and request updates with one click — no phone call needed.

SCAN TO OPEN

2 Our Services

Bandaging

Complete bandaging supplies for the decongestion phase — ask about our free bandaging policy.

Ready-to-Wear Garments

Off-the-shelf compression garments from every major vendor, shipped fast.

Made-to-Measure Garments

Custom-measured garments with our no-fault measurement guarantee — perfect fit, every time.

Plus…

Mastectomy products, lymphedema pumps & specialized garments — just ask!

May We Take Your Order?

To place an order, call, fax, or email us at:

888.358.1580

443.455.1402 fax
orders@comfortcaremd.com

comfortcaremd.com

Some Manufacturers We Work With

A sampling of the manufacturers we order from — this list is not all-inclusive. If what your patient needs isn't in this book, ask — we can get it.

Compression & Lymphedema

- medi
- JOBST
- LR Compression
- Juzo
- THUASNE
- sigvaris
- HADDENHAM
- BIOFLECT®
- barton·carey — Innovating Bum and Vascular Care
- lymphedivas — medically correct fashion for lymphedema
- Bio Concepts — compression garments
- PURE MEDICAL

Mastectomy & Post-Surgical

- Wear Ease INC. — Comfort with Style
- nearly me®
- CLASSIQUE
- Anita — SINCE 1886
- Almost U PROSTHETICS
- PRAIRIE WEAR

Since 1984	150,000+	40+
lymphedema & compression care	patients served	states

Logos and brand names are the property of their respective owners and are used to identify the products we supply.



Comfort Care Medical

Lymphedema Treatment Act

Referral & Documentation Guide

For referring practitioners and lymphedema therapy teams — what the LTA covers, what we need to fill an order, and how to document custom garments to establish medical necessity.

1 What the LTA Covers

- **Daytime:** up to three (3) garments or adjustable wraps per affected body area, once every six (6) months.
- **Nighttime:** up to two (2) garments per affected body area, once every two (2) years (24 months).
- A new set may be covered sooner for a change in the patient's condition, or for loss, theft, or irreparable damage.
- **Medicare & Medicare Advantage: prescribe the full set together.** The clock starts when the first garment ships, so garments added later in the window can be denied as a frequency overlap. Commercial plans set their own limits.

2 Qualifying Diagnoses

Medicare & Medicare Advantage require one of the four diagnoses below — no exceptions. **Commercial plans** are often more flexible and may accept related diagnoses such as CVI or lipedema. A code alone doesn't guarantee coverage without documentation.

Code	Description
I89.0	Lymphedema, not elsewhere classified
I97.2	Postmastectomy lymphedema syndrome
I97.89	Other postprocedural complications and disorders of the circulatory system, not elsewhere classified
Q82.0	Hereditary lymphedema

3 Our Process — What We Need From You

Four things. We handle everything else.

- **Patient demographics + insurance card(s)** — we verify coverage before the appointment.
- **Signed Consent Form** (pages 8–10) — at the appointment, or we'll send it to the patient for e-signature.
- **Clinical evaluation** dated within the last 12 months.
- **Completed measuring / order form.**

Then we take it from here — prescription, physician notes, payment, order, delivery ticket. Its signature date is the date of service.

4 Medical Necessity Documentation

Every order needs a physician-signed prescription and a clinical evaluation. **We prefer the prescription up front to prevent delays — but we're more than happy to obtain the physician paperwork for you.** This matters most for bandaging orders, where an up-front prescription keeps the patient's CDT on schedule.

FROM THE PHYSICIAN

A. Physician Notes + Prescription

- A physician-signed prescription for the items ordered.
- **Medicare & Medicare Advantage only:** the lymphedema diagnosis must also be in the treating practitioner's own notes (MD, DO, NP, or PA) — not a PT, OT, or lymphedema therapist's, *even countersigned.*

FROM THERAPY

B. Clinical Evaluation

- The patient's current condition and why they benefit from the specific garment(s) ordered.
- Manufacturer, model, and quantity for each item.
- For custom items: why an off-the-shelf garment won't work (see Section 5).
- For accessories: why each accessory is needed (see Section 6).

(continued on back)

5 Custom vs. Off-the-Shelf Documentation

Medicare has increased audits of lymphedema claims and routinely flags charts with weak custom-vs-OTS narratives. Generic statements like *"patient needs custom because of lymphedema"* or *"due to the size of the legs"* will not hold up. The record has to show why **this** patient can't be served by a standard off-the-shelf garment.

WHEN CUSTOM IS JUSTIFIED — MEDICARE'S RECOGNIZED SCENARIOS (NOT ALL-INCLUSIVE)

- The proximal part of the limb is significantly larger in circumference than the distal part.
- The skin or tissue has folds or contours that require a specific knitting pattern.
- The patient can't tolerate the fabric of a standard garment.
- The patient falls outside the off-the-shelf size range.

What a strong narrative includes

- **Patient-specific rationale** tied to this patient — severe asymmetry, large measurement discrepancies between limb segments, skin folds, contractures, or a history of skin breakdown at standard pressure points.
- **Objective findings** — measurements, limb volume and shape, skin integrity.
- **The specific customization needed and why** — e.g., adjustable Velcro panels for a limb that is actively reducing, or added padding at a specific site.
- **Connection to the plan of care** — how the garment ties to the patient's treatment goals.

HELPFUL, BUT NOT REQUIRED BY MEDICARE

These strengthen a chart — don't treat them as mandatory: notes on any off-the-shelf trial and why it was insufficient, functional/ADL impact, and dated photos of the affected limb.

6 Accessories

If an accessory (silicone band, pad, liner, zipper, etc.) is added to a custom garment, the evaluation must include language explaining why it's needed. **Donning aids** (butlers, foot slippers, donning gloves) are covered too when a patient can't apply the garment without one — same rule: note why it's needed.

7 Examples

ACCEPTABLE

"Diagnosis (per treating physician's notes): I89.0, bilateral lower extremities. **Daytime:** *L&R ReadyWrap Calf, off-the-shelf, XXL, quantity 3, with hybrid socks (patient fits the OTS size range). Daytime gradient compression is needed to control bilateral lower-extremity edema during activity, and the adjustable wrap lets him re-tension it independently as swelling fluctuates through the day.* **Nighttime:** *L&R TributeNight, custom made-to-measure calf, quantity 1, with Velcro adjustable panel, outer jacket, and non-skid foot pads. Custom is required because the patient falls outside the OTS size range and needs adjustability as limb volume reduces (unable to tolerate daily CDT at this time). The Velcro adjustable panel is needed so compression can be re-tensioned as limb volume decreases and overnight fluid shifts occur, maintaining a therapeutic gradient without repeated refitting during active reduction. The outer jacket is needed to apply consistent external compression over the foam channels of the night garment, which cannot deliver effective gradient pressure without it, and to keep the garment positioned through the night. Non-skid foot pads are needed for safety at heel strike and toe-off when he walks at night; because he removes the outer jacket at rest when the added compression becomes too intense and walks in the TributeNight alone, pads are needed on both the garment and the jacket."*

UNACCEPTABLE

"Dx: lymphedema. Daytime: Ready Wrap calf pieces with socks. Patient needs compression to manage swelling. Nighttime: custom Tribute Night calf with Velcro panel, outer jacket, and non-skid pad. Custom is needed due to the size of the legs. The Velcro panel, jacket, and pad are needed for proper fit and comfort. Patient will benefit from compression garments to manage their lymphedema."

This orders the same products with none of the support. There's no ICD-10 code or affected area, and no manufacturer, size, or quantity. Custom is justified only by "size of the legs," which Medicare explicitly rejects. The accessories are lumped together under a generic "fit and comfort" reason instead of each getting its own justification, and nothing links the order to the plan of care.

Questions? Please call or email **Amy Sakowski** at:
410.908.6818 | a.sakowski@comfortcaremd.com

8 Medical Necessity Self-Check

For your reference before sending documentation. You don't need to send this page to us.

DIAGNOSIS & EVALUATION DATE

- ☐ Is a qualifying lymphedema diagnosis documented? *(Medicare/MA: I89.0, I97.2, I97.89, or Q82.0 only)*
- ☐ Is the clinical evaluation dated within the past 12 months?
- ☐ Are the affected body area(s) documented?

CLINICAL EVALUATION

- ☐ Does the evaluation describe the patient's current condition and explain why the patient benefits from the specific garment(s) ordered?
- ☐ Is each item spelled out specifically, including model/make, compression class, style, MTM vs. OTS, and features? *(e.g., "30–40 mmHg below-knee MTM, open toe, with non-skid pads")*
- ☐ Is each garment identified as daytime or nighttime?

CUSTOM GARMENTS

- ☐ For each custom garment, is a recognized, patient-specific justification documented for why the patient needs custom? *Examples: a proximal/distal circumference discrepancy, skin folds, fabric intolerance, or falling outside the OTS size range.*
- ☐ Does the documentation include individualized findings supporting the custom garment in the plan of care?
- ☐ Is the specific customization (e.g., Velcro panel, padding) named, along with why it's needed?
- ☐ Does the justification avoid generic statements like "due to lymphedema" or "due to limb size"?

ACCESSORIES & DONNING AIDS

- ☐ Does each accessory have its own item-specific justification documented in the evaluation?
- ☐ If donning aids are ordered, does your evaluation explain why the patient can't put the garment on without one (e.g., limited grip strength, reach, or mobility)?

QUANTITY & FREQUENCY

- ☐ Does the requested quantity fall within Medicare frequency limits for all affected body areas? *(Daytime: 3 per area every 6 months. Nighttime: 2 per area every 24 months.)*
- ☐ If the quantity exceeds limits or overlaps a prior coverage window, is there documentation of a change in condition, loss, theft, or irreparable damage?
- ☐ Medicare/MA: is the full set for each body area ordered together *(3 daytime / 2 nighttime)* rather than split across visits?

BANDAGING (IF ORDERED)

- ☐ Are bandaging supplies tied to an active decongestive (CDT) phase in the plan of care, with items and quantities listed?

PLAN OF CARE

- ☐ Does the plan of care connect each item to treatment goals (e.g., maintaining reduction, preventing recurrence)?

Without appropriate documentation, we cannot proceed with an order.

Questions? Please call or email **Amy Sakowski** at:
410.908.6818 | a.sakowski@comfortcaremd.com

Patient Intake Form

*Please print clearly. Fields marked * are required to verify benefits.*

No need to copy this over. Send patient demographics in whatever format your clinic already uses — this form is simply here for your convenience.

1 Patient Information

FULL NAME *

DATE OF BIRTH *

GENDER

STREET ADDRESS

APT / UNIT

CITY

STATE

ZIP

MOBILE PHONE *

BILLING PHONE

EMAIL (FOR DELIVERY TICKET E-SIGNATURE)

2 Emergency Contact

NAME

RELATIONSHIP

PHONE

3 Primary Insurance

INSURANCE PROVIDER *

MEDICARE PRIMARY?
☐ Yes ☐ No

POLICY / MEMBER ID *

GROUP NUMBER

BENEFITS PHONE (ON CARD)

NAME OF INSURED (IF NOT PATIENT)

DOB OF INSURED

4 Secondary Insurance

leave blank if none

INSURANCE PROVIDER

POLICY / MEMBER ID

GROUP NUMBER

NAME OF INSURED (IF NOT PATIENT)

DOB OF INSURED

5 Referring Clinic

THERAPIST NAME *

CLINIC NAME

THERAPIST EMAIL

SHIP PRODUCTS TO
☐ Clinic ☐ Patient's home

6 Prescribing Physician

PHYSICIAN NAME *

PHONE

FAX

ADDRESS

PRESCRIPTION ALREADY ISSUED FOR THESE ITEMS?
☐ Yes ☐ No

Fax to 443.455.1402 or email orders@comfortcaremd.com · Questions? 888.358.1580

Notice of Privacy Practices

Effective September 30, 2026

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Please keep this Notice for your records.

Our Duties

- We are required by law to maintain the privacy and security of your protected health information (PHI).
- We must provide you with this Notice of our legal duties and privacy practices and follow the terms of the Notice currently in effect.
- We will notify you promptly if a breach occurs that may have compromised the privacy or security of your PHI.
- We will not use or share your PHI other than as described in this Notice unless you give us written permission.

How We Use and Disclose Your PHI

Treatment. We may use and share your PHI to provide and coordinate your products and services. For example: (1) a request for a prescription will be sent to your prescribing physician as listed by you, or to the PT/OT/nurse/physician who referred you to Comfort Care Medical; (2) PHI may be released to the manufacturer of your medical products, limited to the PHI needed to make and ship your products — in some cases a manufacturer may require photos or additional history about a medical condition to manufacture a product; and (3) PHI may be disclosed to an independent contractor of Comfort Care Medical if measurements need to be taken, who is legally required to keep your information protected.

Payment. We may use and share your PHI to verify your Durable Medical Equipment (DME) benefits, obtain prior authorization, and bill and receive payment from Medicare, Medicaid, or your insurance company. For example, we send your insurer information about the item you received and the medical documentation that supports it.

Health Care Operations. We may use and share your PHI to run our business and improve our services. For example, we may review records for quality and compliance, train our staff, and share information with our accrediting organization and auditors.

Business Associates. We may share PHI with companies that perform services on our behalf, such as billing, software, document management, and secure messaging vendors. They are required by contract to protect your information.

Family and Others Involved in Your Care. Unless you object, we may share PHI with a family member, friend, or caregiver who is involved in your care or helps pay for it. If you are not able to agree or object, we will use our professional judgment to decide what is in your best interest.

Communications About Your Order. We may contact you about your order, delivery, replacements, and payment, as described in our Order Consent Form.

Other Uses and Disclosures Permitted or Required by Law

We may also use or share your PHI without your written authorization when permitted or required by law, including:

- When required by federal, state, or local law.
- For public health activities, such as reporting product problems or adverse events to the FDA, assisting with product recalls, and preventing or controlling disease.
- To report suspected abuse, neglect, or domestic violence to government authorities.
- For health oversight activities, such as audits, investigations, and inspections by Medicare, Medicaid, and other government agencies.
- In response to a court or administrative order, subpoena, or other lawful process in a lawsuit or legal proceeding.
- For law enforcement purposes, such as responding to a warrant or reporting certain crimes.
- To prevent or lessen a serious threat to the health or safety of you, another person, or the public.
- To coroners, medical examiners, funeral directors, and organ and tissue donation organizations.
- For research, when approved through a process that protects your privacy.
- For workers' compensation claims, and for specialized government functions such as military, national security, and protective services.

Where state law gives your information greater protection than federal law (for example, HIV/AIDS, mental health, substance use, or genetic information), we will follow the more protective state law.

Uses That Require Your Written Authorization

We will not use or disclose your PHI for marketing, sell your PHI, or use your PHI for fundraising without your specific written authorization. Any other use or disclosure not described in this Notice will be made only with your written authorization. You may revoke an authorization at any time in writing, except to the extent we have already acted in reliance on it.

Your Rights — You have the right to:

1. Receive a paper or electronic copy of this Notice at any time, even if you agreed to receive it electronically.
2. Inspect and obtain a paper or electronic copy of your PHI. We may charge a reasonable, cost-based fee. We will respond within 30 days.
3. Request corrections (amendments) to your health record if you believe it is incorrect or incomplete. We may deny your request, but we will tell you why in writing within 60 days.
4. Request restrictions on certain uses and disclosures of your PHI for treatment, payment, or health care operations. We are not required to agree to all requests, but we will accommodate reasonable requests when possible. **If you pay for an item or service out of pocket in full, you may ask us not to share information about it with your health plan, and we will agree unless a law requires us to share it.**
5. Request confidential communications (for example, ask us to contact you at a different phone number or address). We will accommodate reasonable requests.
6. Request an accounting of disclosures of your PHI made in the six years before your request (excluding disclosures for treatment, payment, health care operations, and certain other disclosures). One accounting per 12 months is free.
7. Choose someone to act for you, such as a legal guardian or a person with health care power of attorney.
8. File a complaint if you believe your privacy rights have been violated (see below). We will not retaliate against you for filing a complaint.

To exercise any of these rights, contact our Privacy Officer using the information below. Some requests must be made in writing.

Changes to this Notice

We reserve the right to change this Notice and make the new provisions effective for all PHI we maintain. If we make material changes, we will post the new Notice at our office and on our website at www.comfortcaremd.com, and provide you with a copy upon request.

Notice of Privacy Practices (continued)

Complaints

You may file a complaint with us by contacting our Privacy Officer. You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, 200 Independence Avenue SW, Washington, DC 20201; by calling 1-877-696-6775; or online at www.hhs.gov/ocr/complaints.

Contact Information — Privacy Officer

For questions, to exercise your rights, or to file a complaint, contact: Comfort Care Medical Equipment, Attn: Privacy Officer, 1105 N Point Blvd Ste 311, Baltimore, MD 21224 | Toll-free: 1-888-358-1580 | Email: customerservice@comfortcaremd.com

Patient Rights & Responsibilities

Comfort Care Medical Equipment is accredited by the Board of Certification/Accreditation (BOC). As our patient, you have the following rights and responsibilities.

You have the right to:

- Be treated with courtesy, dignity, and respect, without discrimination based on race, color, national origin, religion, sex, age, or disability.
- Receive information about our products and services, including estimated charges and your expected financial responsibility, before your item is provided.
- Choose your DME supplier, and be informed of any supplier or product limitations under your insurance plan.
- Participate in decisions about your products, and refuse any product or service after being informed of the possible consequences.
- Receive instruction on the proper use, wear, and care of your products, and be informed of warranty coverage and our return and exchange policies.
- Privacy of your health information and access to your records, as described in the Notice of Privacy Practices above.
- Receive free language assistance or auxiliary aids if you need them to communicate with us.
- Voice complaints without fear of discrimination, reprisal, or interruption of service, and be told how your complaint was resolved.

You are responsible for:

- Providing complete and accurate information about your health, insurance, and contact details, and telling us promptly about changes, including new insurance, a new address, electing hospice, or admission to a hospital, nursing home, or other facility.
- Following your physician's or therapist's instructions and the wear and care instructions for your products.
- Signing required documents, including the Order Consent Form and Delivery Ticket (Proof of Delivery), in a timely manner.
- Paying amounts that are your financial responsibility under your insurance plan.
- Notifying us promptly of any problem with the fit, function, or quality of your products, and treating our staff with courtesy and respect.

Purchase Items: All items are provided on a purchase basis. We do not offer rental equipment.

Complaint & Grievance Process

For any question, concern, or complaint, contact **Comfort Care Medical Equipment, Attn: Compliance**, 1105 N Point Blvd Ste 311, Baltimore, MD 21224 | 1-888-358-1580 | customerservice@comfortcaremd.com. Within 5 calendar days of receiving your complaint, we will let you know it was received and is being investigated. Within 14 calendar days, we will send you written notice of the results. Every complaint is documented and kept on file.

If your concern is not resolved to your satisfaction, you may also contact **BOC**, our accrediting organization, at 1-877-776-2200 (Monday–Friday, 8:00 AM–5:00 PM ET), or **Medicare** at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048.

Medicare DMEPOS Supplier Standards

The products and/or services provided to you by Comfort Care Medical Equipment, LLC are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will furnish you a written copy of the standards.

Order Consent Form

Please read each section carefully. Your signature below confirms you have read, understood and agree to all six sections.

1 Insurance Coverage & Financial Obligation

As a courtesy to you, Comfort Care Medical verifies your insurance coverage before processing an order or submitting any claim; however, verifying coverage under your plan remains your responsibility, and we strongly encourage you to confirm your benefits. Any financial obligation will be clearly explained to you. Patients are responsible for all amounts deemed their responsibility by their insurance plan, including copays, deductibles, coinsurance, and non-covered services. Coinsurance and deductibles vary by policy, and we can only approximate the percentage covered by each plan. Payment of the estimated portion is due at the time of service, before Comfort Care processes the order. If we have overestimated your fees, the excess will be refunded to you within 30 days after your insurance processes the claim; if we have underestimated, we anticipate prompt payment of the balance. **Comfort Care Medical will not collect Medicare deductibles, coinsurance, or copays from patients enrolled in the Qualified Medicare Beneficiary (QMB) program, and will not bill Medicaid recipients for any amount that Medicaid rules prohibit us from collecting.** Comfort Care Medical will manage all appeals and denials on your behalf, allowing you to concentrate on your health and well-being. **Interest-free payment plans are available.**

2 Communication Consent

I authorize Comfort Care Medical to contact me by phone, voicemail, text message, or email regarding my orders, account, billing, documentation requests, insurance requirements, and related services, using contact information provided by me or supplied through my referring provider or healthcare facility. I understand that standard text messaging and unencrypted email may not be fully secure methods of communication, and by signing this consent I acknowledge and accept this risk. I may request encrypted email or phone-only contact at any time, and I may withdraw consent for text or email communication at any time by notifying Comfort Care Medical in writing. Revocation will not affect prior communications but may impact the timeliness of updates regarding my order or insurance processing.

3 Order Consent / Assignment of Benefits

I authorize Comfort Care Medical to fulfill the order of the device prescribed by my physician and to bill my insurance company, and I authorize my insurance company to release payment of all monies to Comfort Care Medical to satisfy the total billed amount for all services. **Medicare Assignment:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Comfort Care Medical Equipment for any items or services furnished to me by Comfort Care Medical. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, and to any other insurer, any information needed to determine these benefits or the benefits payable for related services. This assignment and authorization remain in effect until I revoke them in writing. I agree to accept the item(s) when notified by Comfort Care Medical that the order has been fulfilled. I understand that Comfort Care Medical will verify insurance and request authorization from my insurance company as a courtesy; however, I acknowledge that insurance verification and authorization do not guarantee payment. In the event a claim is denied and any appeal is unsuccessful due to factors outside of Comfort Care Medical's control — including inaccurate or incomplete information provided by myself, failure to return a required Proof of Delivery (POD), or failure to disclose hospice care or residence in a nursing or institutional facility — I understand that I may be financially responsible for the cost of the garment, to the extent permitted by Medicare rules and my insurance plan's contract. **Medicare patients:** if Comfort Care Medical expects that Medicare may deny payment for an item because it may not be considered medically reasonable and necessary, I will be asked to sign a separate Advance Beneficiary Notice of Noncoverage (ABN) before the item is provided; without a signed ABN, I will not be held financially responsible for that type of denial. If credit terms have been provided, I agree to pay the total amount on the invoice within the terms on file with Comfort Care Medical.

4 Acknowledgment of Notices & Authorization for Release of Medical Records

Comfort Care Medical has provided me with its Notice of Privacy Practices, its Patient Rights & Responsibilities (including its complaint process), and the Medicare DMEPOS Supplier Standards, and I understand how my protected health information (PHI) will be used in connection with obtaining medical products and services. By signing this consent, I authorize my physician(s), therapist(s), clinician(s), healthcare facilities, and any other treating providers to release and disclose to Comfort Care Medical any medical records necessary to process my order, including but not limited to prescriptions, physician notes, progress notes, evaluations, diagnostic information, and documentation supporting medical necessity. I understand that Comfort Care Medical may use and disclose my medical information for treatment, payment, and healthcare operations, and for other purposes permitted or required by law; that certain PHI is required to bill my insurance company; and that only the minimum necessary information for billing and compliance purposes will be disclosed. This authorization remains in effect until I revoke it in writing, except to the extent Comfort Care Medical has already relied on it. Comfort Care Medical is a healthcare provider and complies with all applicable HIPAA regulations governing the use and protection of PHI.

5 Proof of Delivery & Date of Service

After I receive my items, insurance requires a signed Delivery Ticket (Proof of Delivery) before any claim can be submitted for coverage; my signature confirms to my insurance company that I received the items ordered. **I understand that the date I sign the Delivery Ticket becomes the official date of service reported to insurance,** which may impact my deductible or out-of-pocket responsibility if my benefits reset before it is signed. Timely signature helps ensure proper benefit application and avoids unnecessary delays or unexpected financial responsibility.

6 Warranty & Returns

Comfort Care Medical honors all warranties under applicable state law and manufacturer terms, and will inform you of the warranty coverage for your item. If any Medicare-covered item or component fails during the manufacturer's warranty period, Comfort Care Medical will repair or replace the item at no cost to you, and you will not be billed for warranty-covered repairs or replacements. Once the garment has been received by Comfort Care Medical from the vendor, you have 30 days to be fit with the garment; delays may affect the manufacturer's warranty coverage. Comfort Care Medical will accept the return of any item that is substandard (less than full quality) or unsuitable (inappropriate for you at the time it was fitted or sold). Because garments are made or selected to your measurements, items that are free of defects and correctly sized cannot be returned for personal preference alone; however, if an item is difficult to put on, take off, or uncomfortable, Comfort Care Medical will remeasure you to verify sizing and replace or exchange the item when appropriate. Your signature below acknowledges that you have been instructed on the use, wear, care, and warranty of prescribed products, and that you understand Comfort Care Medical will honor all applicable warranties in compliance with Medicare requirements.

PATIENT NAME

PATIENT SIGNATURE | DATE

LEGAL REP NAME (IF APPLICABLE)

LEGAL REP SIGNATURE | DATE

Track your order: check the status of your order anytime at **comfortcaremd.com/track-order** using your Sales Order ID.

Comfort Care Medical Equipment
1105 N Point Blvd Ste 311, Baltimore, MD 21224
Phone: 888.358.1580
customerservice@comfortcaremd.com

Patient Handout

What Happens After You Sign Your Consent Form

Your part is simple: pay your estimated portion, and sign your Delivery Ticket when your items arrive. We handle everything else.

1 You Pay Your Estimated Portion

Your estimated share is due before we place your order. Coverage varies by plan, so this is an estimate: if we overestimated, we refund the difference once your insurance processes the claim; if we underestimated, you'll receive a bill for the remaining balance shown on your insurance's Explanation of Benefits. **High deductible or large out-of-pocket cost? Interest-free payment plans are available — just ask.**

2 We Handle the Paperwork

We verify your coverage, obtain any prior authorization, and collect the prescription and clinical notes from your providers — Medicare also requires physician notes confirming your diagnosis. **We request all of this directly from your providers; we'll only contact you if we need a hand.**

3 We Place Your Order

As soon as payment and paperwork are in, your order goes out. Paying out of pocket with no insurance? Your order is placed the moment payment is received — no paperwork needed.

4 You Sign Your Delivery Ticket

When your items arrive, you'll get an email with a Delivery Ticket to e-sign. This tells your insurance you received your items — we can't file your claim without it. Don't see the email? Check spam or junk. We'll send a reminder every 3 days until it's signed, or mail a copy if we have no email on file.

Sign it right away — the date matters. The date you sign becomes your official date of service. If your items arrive in December but you sign in January, the claim lands in the new year, and your deductible may have reset. Sign promptly and your claim is filed fast with your benefits applied as expected.

Staying overnight in a hospital or facility? Wait until you're home to sign your Delivery Ticket. Insurance does not cover these items on any day you're an inpatient — including a hospital, nursing home, or rehab facility. Signing during your stay can cause your claim to be denied.

Comfort Care Medical

FAX

Comfort Care Medical · Fax 443.455.1402 · Phone 888.358.1580 · orders@comfortcaremd.com

TO

Physician: _____

Practice: _____

Fax: _____

Attn: _____

Patient: _____

FROM

Therapist: _____

Clinic: _____

Phone: _____

Date: _____

Pages (incl. cover): _____

REQUESTED: ☐ Signed prescription (attached) ☐ Supporting office note ☐ Other: _____

Compression Garment Coverage

Medicare / Lymphedema Treatment Act — two items are needed from your office. Thank you for helping our shared patient.

1 Sign the attached prescription

It is already completed for your patient. Your office only needs to **review, sign, and return** it.

2 Send a supporting office note

For Medicare, a signed prescription alone is not sufficient. We also need an office or clinical note, **in the physician's own notes**, that documents the qualifying diagnosis:

VISIT DATE	Any office visit date is acceptable.
ICD-10 CODE	**I89.0** Lymphedema, NEC · **I97.2** Postmastectomy lymphedema syndrome · **I97.89** Other postprocedural circulatory complications · **Q82.0** Hereditary lymphedema
AFFECTED AREA	Identify the extremity or area — e.g. "left upper extremity lymphedema," "bilateral lower extremity lymphedema."

A therapist's evaluation — even countersigned by the physician — does not satisfy this requirement.

Why both? The prescription tells us what to supply. The office note documents the diagnosis Medicare requires.

RETURN BOTH TO COMFORT CARE MEDICAL

Fax 443.455.1402 · orders@comfortcaremd.com · Questions? 888.358.1580

We handle benefits verification, authorization, delivery and billing — nothing else is needed from your office.

This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged, confidential, and/or exempt from disclosure under applicable law. If you are not the intended recipient, please notify the sender immediately and destroy this document.

Comfort Care Medical

Standard Written Order

Bandaging Form

Phone 888.358.1580 · Fax 443.455.1402 · comfortcaremd.com

PLEASE FILL OUT EACH SECTION · INCLUDE THE PATIENT'S DEMOGRAPHICS TO AVOID DELAYS
Completed & signed orders: fax to Comfort Care Medical at 443.455.1402

SECTION 1 GENERAL INTAKE INFORMATION

Patient name: _____ **Order start date:** ____ / ____ / ____

Patient phone: _____ **Patient DOB:** ____ / ____ / ____

Referral facility: _____

Referral phone: _____ **City:** _____ **State:** _____ **Fax:** _____

Medicare beneficiary? ☐ Yes ☐ No *If yes, please send physician notes with this prescription confirming the diagnosis checked below.*

SECTION 2 DIAGNOSIS INFORMATION

To ensure eligibility for insurance coverage, the patient's medical record must confirm the information provided below.

Location being treated: ☐ Left leg ☐ Right leg ☐ Left arm ☐ Right arm ☐ Other: _____

☐ **I89.0** Secondary lymphedema due to (etiology): _____
☐ **I97.2** Secondary lymphedema, post-mastectomy
☐ **Q82.0** Primary lymphedema (congenital / hereditary), including lymphedema tarda
☐ **I97.89** Postprocedural complications and disorders of the circulatory system (etiology): _____

Duration of need: ☐ Lifetime ☐ Other, please explain: _____

SECTION 3 PRODUCT SELECTION — COMPRESSION BANDAGING SUPPLIES

Circle the size and write the quantity for each item ordered. Quantity (QTY) must be included in the medical record.

A. STOCKINETTE & TUBULAR — QTY

Polysoft Stockinette (×25yd) 2in 3in 4in 6in 8in _____
Tricofix Tubular (×20m) 6cm 8cm 10cm 12cm _____
TG Tubular Sz 6 Sz 7 Sz 9 Sz 12 K1 K2 _____
TG Grip Support (×10m) A 4.6cm D 7.5cm G 12cm _____
TG Soft Tubular Padding S M L _____

B. PADDING & FOAM — QTY

Artiflex Padding (×3m) 10cm 15cm _____
Cellona Undercast (×3m) 6cm 10cm 15cm _____
Komprex Foam Pad Sz 00 Sz 0 Sz 1 (12×1.2cm) _____
Komprex Foam Sheet 50cm×1m×1cm _____
Rosidal Soft Foam (×2.5m) 10cm 12cm 15cm _____
Sigvaris Grayfoam 1/4in 1/2in _____
Comprifoam (×2.5m) 10cm 12cm _____

H. OTHER / WRITE-IN (ITEMS NOT LISTED ABOVE) — QTY

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

C. CONFORMING / GAUZE — QTY

Mollelast Conforming (×4m) 4cm 6cm 10cm _____
Transelast Classic (×4m) 4cm 6cm _____
Elastomull Gauze (×4.4yd) 1in 2in 3in _____

D. SHORT-STRETCH COMPRESSION (CM × M) — QTY

Rosidal K 4×5 6×5 8×5 10×5 10×10 12×5 12×10 _____
Comprilan 4×5 6×5 8×5 10×5 10×10 12×5 12×10 _____

E. ELASTIC / ALL-PURPOSE — QTY

Idealbinde (×5m) 15cm _____
Lenkelast (×5m) 8cm 10cm 12cm 15cm 20cm _____

F. FINISHING & TAPE — QTY

Isoband Finished Edge (×5yd) 6in 8in _____
Silkafix Tape (×5m) 2.5cm (12pk) 5cm (6pk) _____

G. SPECIALTY — QTY

Dauerbind K Long-Stretch 8cm×7m _____
Gelocast Unna Boot 3in×10yd _____

SECTION 5 AUTHORIZATIONS

Is the patient requesting coordination of care? ☐ Yes ☐ No

(The patient has chosen Comfort Care to assist in providing the requested care by providing product, verifying insurance benefits, billing for service(s), or coordinating care should direct service not be an option.)

SECTION 6 PHYSICIAN SIGNATURE — ALL FIELDS REQUIRED

Physician name: _____ **Physician phone:** _____

Physician NPI: _____ **Physician fax:** _____

Signature: _____ **Date:** _____

Comfort Care Medical

Phone 888.358.1580 · Fax 443.455.1402 · comfortcaremd.com

Standard Written Order

Made-to-Measure Compression Form

PLEASE FILL OUT EACH SECTION · INCLUDE THE PATIENT'S DEMOGRAPHICS & MEASURING FORM(S) TO AVOID DELAYS

Completed & signed orders: fax to Comfort Care Medical at 443.455.1402

SECTION 1 GENERAL INTAKE INFORMATION

Patient name: _____ **Order start date:** ____ / ____ / ____

Patient phone: _____ **Patient DOB:** ____ / ____ / ____

Referral facility: _____

Referral phone: _____ **City:** _____ **State:** _____ **Fax:** _____

Medicare beneficiary? ☐ Yes ☐ No *If yes, please send physician notes with this prescription confirming the diagnosis checked below.*

SECTION 2 DIAGNOSIS INFORMATION

To ensure eligibility for insurance coverage, the patient's medical record must confirm the information provided below.

Location being treated: ☐ Left leg ☐ Right leg ☐ Left arm ☐ Right arm ☐ Other: _____

☐ **I89.0** Secondary lymphedema due to (etiology): _____

☐ **I97.2** Secondary lymphedema, post-mastectomy

☐ **Q82.0** Primary lymphedema (congenital / hereditary), including lymphedema tarda

☐ **I97.89** Postprocedural complications and disorders of the circulatory system (etiology): _____

Duration of need: ☐ Lifetime ☐ Other, please explain: _____

SECTION 3 ITEMS TO BE DISPENSED

Quantity (QTY) must be included in the medical record. Accessories must be written out clearly, line by line.

QTY	LT / RT	DAY / NIGHT	Item description (garment type, compression level, options)
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	

SECTION 5 AUTHORIZATIONS

Is the patient requesting coordination of care? ☐ Yes ☐ No

(The patient has chosen Comfort Care to assist in providing the requested care by providing product, verifying insurance benefits, billing for service(s), or coordinating care should direct service not be an option.)

SECTION 6 PHYSICIAN SIGNATURE — ALL FIELDS REQUIRED

Physician name: _____ **Physician phone:** _____

Physician NPI: _____ **Physician fax:** _____

Signature: _____ **Date:** _____

Comfort Care Medical

Phone 888.358.1580 · Fax 443.455.1402 · comfortcaremd.com

Standard Written Order

Ready-to-Wear Compression Form

PLEASE FILL OUT EACH SECTION · INCLUDE THE PATIENT'S DEMOGRAPHICS TO AVOID DELAYS

Completed & signed orders: fax to Comfort Care Medical at 443.455.1402

SECTION 1 GENERAL INTAKE INFORMATION

Patient name: _____ **Order start date:** ____ / ____ / ____

Patient phone: _____ **Patient DOB:** ____ / ____ / ____

Referral facility: _____

Referral phone: _____ **City:** _____ **State:** _____ **Fax:** _____

Medicare beneficiary? ☐ Yes ☐ No *If yes, please send physician notes with this prescription confirming the diagnosis checked below.*

SECTION 2 DIAGNOSIS INFORMATION

To ensure eligibility for insurance coverage, the patient's medical record must confirm the information provided below.

Location being treated: ☐ Left leg ☐ Right leg ☐ Left arm ☐ Right arm ☐ Other: _____

☐ **I89.0** Secondary lymphedema due to (etiology): _____

☐ **I97.2** Secondary lymphedema, post-mastectomy

☐ **Q82.0** Primary lymphedema (congenital / hereditary), including lymphedema tarda

☐ **I97.89** Postprocedural complications and disorders of the circulatory system (etiology): _____

Duration of need: ☐ Lifetime ☐ Other, please explain: _____

SECTION 3 MEASUREMENTS AND READY-TO-WEAR LYMPHEDEMA PRODUCTS

LOWER EXTREMITY MEASUREMENTS (CM)

Ankle (circ.)	**LT**	_____	**RT**	_____
Calf (circ.)	**LT**	_____	**RT**	_____
Length: heel – knee	**LT**	_____	**RT**	_____
Thigh (circ.)	**LT**	_____	**RT**	_____
Length: heel – buttocks	**LT**	_____	**RT**	_____

UPPER EXTREMITY MEASUREMENTS (CM)

Palm (circ.)	**LT**	_____	**RT**	_____
Wrist (circ.)	**LT**	_____	**RT**	_____
Elbow (circ.)	**LT**	_____	**RT**	_____
Axilla (circ.)	**LT**	_____	**RT**	_____
Length: wrist – axilla	**LT**	_____	**RT**	_____

Quantity (QTY) must be included in the medical record. Daytime allowables: 3 per area / 6 months. Nighttime allowables: 2 per area / 2 years.

KNEE-HIGH

Daytime garment

☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____

Nighttime garment

☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____

Compression level

18–30 mmHg	☐ LT	☐ RT
30–40 mmHg	☐ LT	☐ RT
> 40 mmHg	☐ LT	☐ RT

THIGH-HIGH

Daytime garment

☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____

Nighttime garment

☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____

Compression level

18–30 mmHg	☐ LT	☐ RT
30–40 mmHg	☐ LT	☐ RT
> 40 mmHg	☐ LT	☐ RT

ARM / HAND

Daytime garment

☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____

Nighttime garment

☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____

Compression level

18–30 mmHg	☐ LT	☐ RT
30–40 mmHg	☐ LT	☐ RT
> 40 mmHg	☐ LT	☐ RT

SECTION 4 NOTES

Other products / comments: _____

SECTION 5 AUTHORIZATIONS

Is the patient requesting coordination of care? ☐ Yes ☐ No

(The patient has chosen Comfort Care to assist in providing the requested care by providing product, verifying insurance benefits, billing for service(s), or coordinating care should direct service not be an option.)

SECTION 6 PROVIDER SIGNATURE — ALL FIELDS REQUIRED

Provider name: _____ **Provider phone:** _____

Provider NPI: _____ **Provider fax:** _____

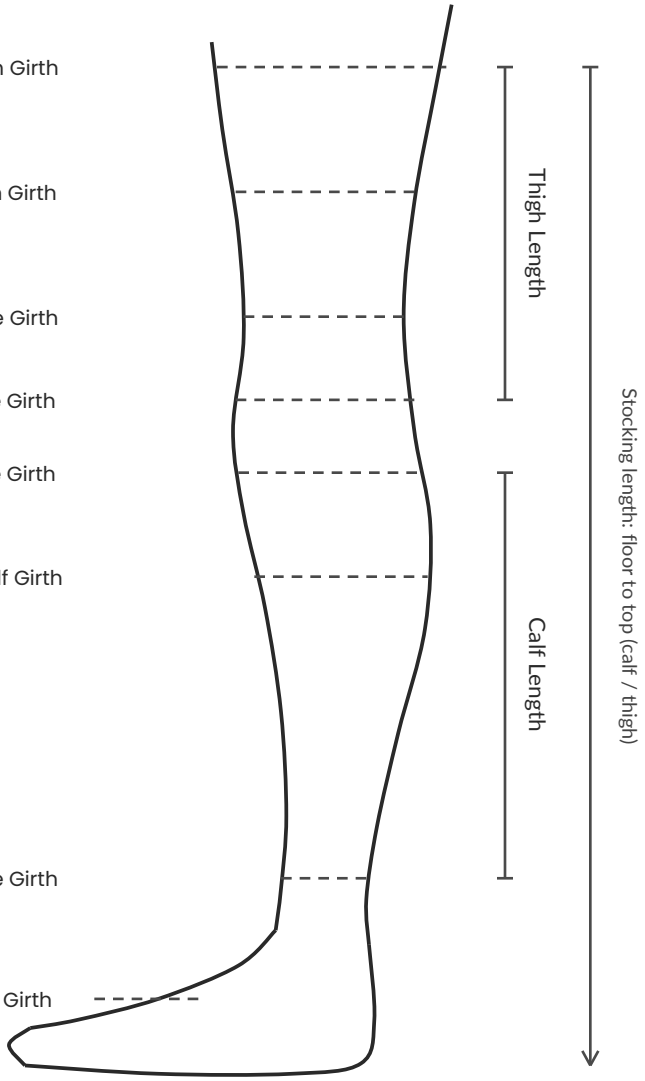
Signature: _____ **Date:** _____

LE Measurement Chart

Patient's Name: _____ Date: _____

Phone #: _____ Therapist: _____

LEFT	RIGHT	
_____	_____	Groin Girth
_____	_____	Mid Thigh Girth
_____	_____	Above Knee Girth
_____	_____	Mid Knee Girth
_____	_____	Below Knee Girth
_____	_____	Largest Calf Girth
_____	_____	Ankle Girth
_____	_____	MTP Girth
_____	_____	Heel to MTP
_____	_____	Foot Length



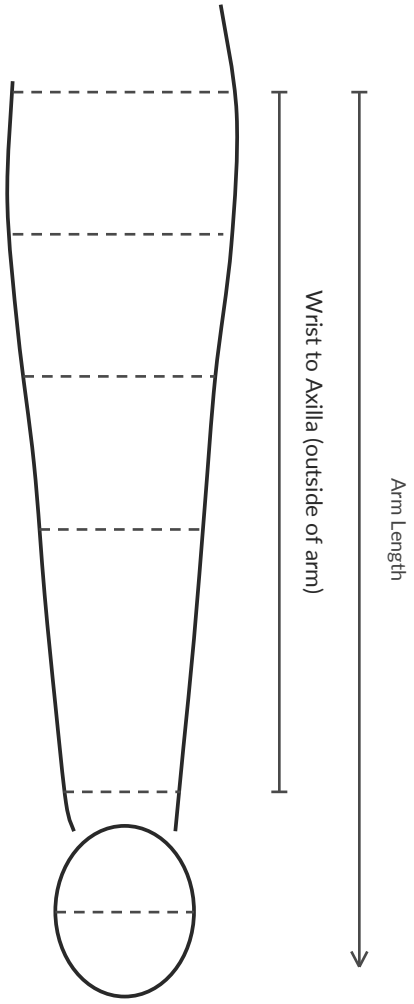
NOTES

UE Measurement Chart

Patient's Name: _____ Date: _____

Phone #: _____ Therapist: _____

LEFT	RIGHT	
_____	_____	Axilla Girth
_____	_____	Upper Arm Girth
_____	_____	Elbow Crease Girth
_____	_____	Forearm Girth
_____	_____	Wrist Girth
_____	_____	MCP Girth



Band Measurements (mastectomy garments)

Step 1a - band girth under bust: _____

Step 2 - over fullest part of chest: _____

NOTES

mediven®
Bolero Order Form

medi

Customer Name _____

Account #_____

P.O.#_____

Patient Name_____

Date Measured_____

Measured By_____

Exact Reorder Number_____

Bill to: _____

_____

Ship to:_____

_____

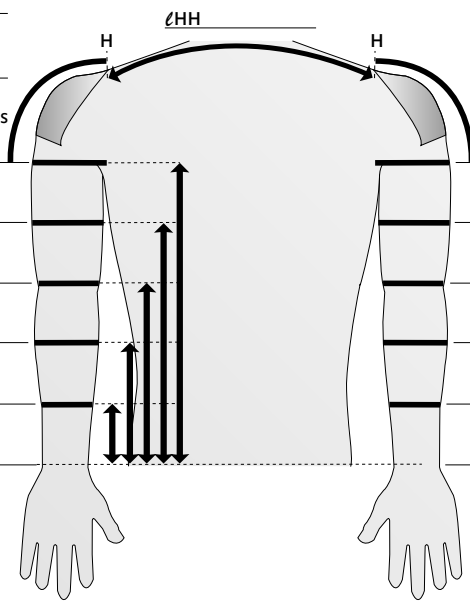
Notes: _____

_____

_____

BOLERO left - Circumference C and lengths ℓ

BOLERO right– Circumference C and lengths ℓ



**Skin measurements optional.

**Skin measurements optional.

Model	Compression CCL 1 2 3	Standard colors	Trend colors	Quantity
☐ mediven mondi 350 Arm ☐ mediven 550 Arm	CCL 1 (15-21 mmHg) CCL 2 (23-32 mmHg) CCL 3 (34-46 mmHg) Armsleeve ☐ ☐ ☐	☐ medi Magenta ☐ Cashmere ☐ Sand ☐ Navy ☐ Caramel ☐ Anthracite ☐ Black ☐ Grey ☐ Chestnut*	☐ Russet-red* ☐ Sage-green* ☐ Light-blue* ☐ Lilac*	pcs. _____

Variants	Border		
☐ CG	☐ flat oblique	☐ steep oblique	☐ straight

Accessories
Knitting marks elbow 160° (Standard) ☐ 150° ☐ 135° ☐ Flexure functional zone elbow (only mediven 550)

Other accessories		Anti-slip-dots
Position	Topband pieces	
☐ along the oblique border	☐ 5 x 2.5 cm ☐ 5 x 5 cm ☐ 10 x 5 cm	☐ 6 x 4.5 cm
_____ cm porous in armsleeve (distal – standard 2 cm)		
☐ Lymphpad ☐ Lining ☐ Pocket (Please specify / draw position exactly!)		
Design Elements: (single-color pattern) ☐ Stripes* ☐ Nature* ☐ Bloom* ☐ Wild*		**Fashion Elements:** (two-toned pattern) ☐ Stripes* ☐ Nature* ☐ Bloom* ☐ Wild*

* Requires 10 additional working days for production.

6481 Franz Warner Parkway Whitsett, NC 27377

P0966 Rev B

CIRCAID Custom Armsleeve & Glove Form

☐ Exact Reorder Order Number: _____
RMA #: _____

medi

Customer Name _____

Customer No. _____ Purchase Order No. _____

Patient Name _____ Fax _____

Billing Address _____

_____

Shipping Address _____

_____

Telephone _____ Measured by _____

Order Date _____ Email _____

Shipping method: ☐ Standard (max. 5 days if complete order is received by 3:00pm EST) ☐ Second Day (extra charge) ☐ Next Day (extra charge)

Credit Card Info _____

juxtafit® essentials arm

Color ☐ Beige ☐ Black NEW

	Qty Left	Qty Right	Standard arm sleeve (C-G)	Partial sleeve (C-E)	Partial sleeve (E-G)	Partial sleeve (C-F)	Made of extra-firm material
armsleeve							

juxtafit® essentials glove

Color ☐ Beige ☐ Black NEW

*open palm is recommended for palm circumferences greater than 24cm	Qty Left	Qty Right	Fingerless glove	Extend wrist band
glove				☐3cm ☐6cm
open palm glove				☐3cm ☐6cm
glove w/ dorsum strap				☐3cm ☐6cm
open palm glove w/ dorsum strap				☐3cm ☐6cm
hand wrap				

Cover up color

(indicate qty.)

____ black **(default)**

____ beige

____ pink

Additional Options

Undersleeves (indicate qty.)

____ standard

____ silver

____ wide

*New custom options and add-ons may incur additional costs.

graduate™

	Qty Left	Qty Right	Foam lateral rise	Stop foam at C	Tack thumb hole	Band locks
armsleeve			☐2.5cm ■5cm			

graduate™ foam liner color options

Interior	Exterior
☐ Beige **(default)**	☐ Black **(default)** ☐ Beige

Norton Hand Solution	Qty Left	Qty Right
shell and black glove		
shell and black glove with open palm		

Notes on taking measurements for custom-made circaid inelastic products

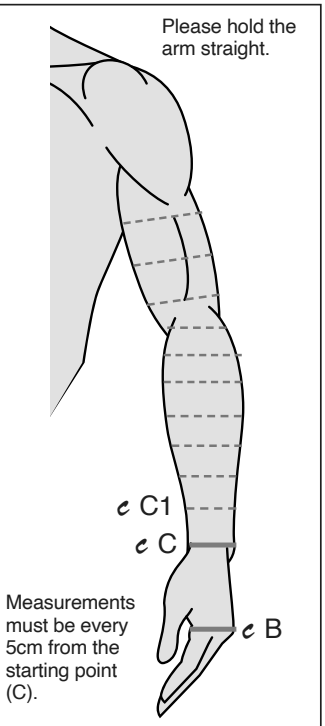
- Measurements for compression garments should not be taken until the best possible decongestion effort has been achieved. Circumference and length measurements are taken in a distal to proximal sequence. Measurements should be taken with the arm extended straight, such as with a patient lying flat on a table or standing.
- It is essential to mark the measuring points on the arm so that the circumference and length measurements are taken at the same point.
- The circumference measurements are taken without any tension as the products are adjustable and will accommodate some changes in size. Measurements are to be taken with skin measurements. Skin measurements should be taken loosely without tension.

Please take measurements without tension!

Patient Name: _____ Date: _____

Arm measurement Circumferences

Left in cm.		Right in cm.
	55	
	50	
	45	
	40	
	35	
	30	
	25	
	20	
	15	
	10	
	05 ℄C1	
	℄C wrist	
	℄B Palm	

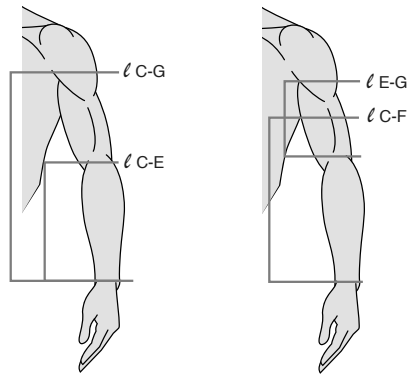


Arm measurement Lengths

Left in cm.		Right in cm.
	ℓ C-G	
	ℓ E-G	
	ℓ C-F	
	ℓ C-E	

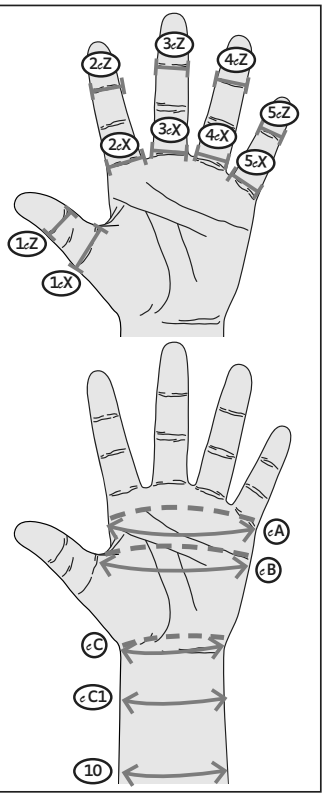
*Only ℓC-E and ℓC-G required for standard arm sleeve. Other measurements only needed for partial arm sleeves depending on sleeve end point.

Please measure the length on the inside of the arm in a straight line.



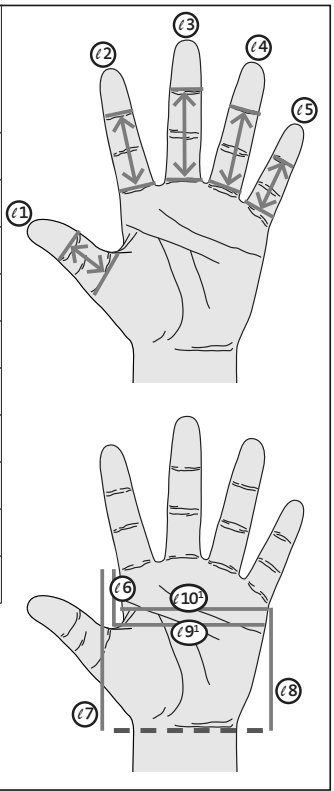
Hand measurement Circumferences

Left in cm.		Right in cm.
	1℄z	
	2℄z	
	3℄z	
	4℄z	
	5℄z	
	1℄x	
	2℄x	
	3℄x	
	4℄x	
	5℄x	
	℄A	
	℄B Palm	
	℄C Wrist	
	℄C1*	
	10*	



Hand measurement Lengths

Left in cm.		Right in cm.
	ℓ1	
	ℓ2	
	ℓ3	
	ℓ4	
	ℓ5	
	ℓ6	
	ℓ7	
	ℓ8	
	ℓ9[1]	
	ℓ10[1]	



*C1 and 10 required for extended wrist band on glove. 10 = 10 cm above C (wrist) measurement.

[1]When measuring these points, press the palm flat on top of the measuring tape on a hard flat surface and measure the widths from the lateral edges of the hand.

Compression for Lymphedema

Referral Form – send to preferred Compression Dealer custom-made

medi

Date: _____

Clinic Name: _____

Patient Name: _____

Therapist Name: _____

Diagnosis: _____ ICD-10 Code: _____

Physician Signature: _____

NPI #: _____

Refills: _____

Notes_____

_____

_____

_____

_____

Printed Name: _____

Phone: _____

Upper Extremity

Affected Limb: ☐ Left ☐ Right ☐ Bilateral

Enter quantity of desired style in blank space.

Compression for mediven flat-knit products:

☐ 15-21 mmHg ☐ 23-32 mmHg ☐ 34-46 mmHg

mediven flat-knit products:

☐ **mediven 550** ☐ **mediven mondi 350**

☐ glove_____ ☐ gauntlet_____ ☐ arm sleeve_____ ☐ other_____

compliance aids: ☐ arm butler_____ ☐ application gloves_____

circaid products:

circaid juxtafit ☐ arm sleeve_____ ☐ glove_____

circaid profile nighttime ☐ arm sleeve_____ ☐ glove_____ ☐ oversleeve_____

circaid profile options ☐ finger foam zones ☐ fused EZ-on ☐ high-energy oversleeve ☐ other _____

Lower Extremity

Affected Limb: ☐ Left ☐ Right ☐ Bilateral

Enter quantity of desired style in blank space.

Compression for mediven flat-knit products: **550 only

☐ 18-21 mmHg ☐ 23-32 mmHg ☐ 34-46 mmHg ☐ 49-60 mmHg**

mediven flat-knit products:

☐ **mediven mondi 350** ☐ **mediven cosy 450** ☐ **mediven 550**

☐ toe cap_____ ☐ knee_____ ☐ thigh_____ ☐ waist_____ ☐ other_____

compliance aids: ☐ leg butler_____ ☐ application gloves_____ ☐ butler off_____

circaid products:

circaid juxtafit

☐ lower leg_____ ☐ whole leg_____ ☐ upper leg_____ ☐ upper leg w/knee_____

circaid foot options

☐ pac band_____ ☐ juxtafit afw_____ ☐ customizable interlocking_____ ☐ other_____

circaid profile nighttime ☐ lower leg_____ ☐ whole leg_____ ☐ oversleeve_____

circaid profile options ☐ Non skid ☐ EZ-open panel ☐ other_____

circaid® Custom Legging Form

☐ Exact Reorder Order
Number: _____

medi

Date _____ Physicians Printed Signature _____

NPI _____ Physicians Signature _____

Customer Name _____

Customer No. _____ Purchase Order No. _____

Patient Name _____ Fax _____

Billing Address _____

_____

Shipping Address _____

Measured by _____

Telephone _____

Order Date _____ Email _____

Diagnosis: ICD-10 - check all that apply
☐ I89.0 Lymphedema, not elsewhere classified
☐ I97.2 Postmastectomy lymphedema syndrome
☐ I97.89 Other postprocedural complications and disorders of the circulatory system, not elsewhere classified
☐ Q82.0 Hereditary lymphedema

Shipping method: ☐ Standard (max. 5 days after complete order is received) ☐ Second Day (extra charge) ☐ Next Day (extra charge)

Credit Card Info _____

juxtafit® premium

	Qty Left	Qty Right	Lateral rise (oblique)	Add pull tabs	Add Ez-on panel
Lower leg			☐ No rise **(default)** ☐ 5cm ☐ 10cm		
Knee only					
Upper leg			☐ Yes **(default)** ☐ No		
Upper leg w/knee			☐ Yes **(default)** ☐ No		
Whole leg *(one piece)*			☐ Yes **(default)** ☐ No		
Custom foot					

Additional Options

☐ pac band™
compression anklets included
☐ single band afw™
☐ juxtafit premium interlocking afw
☐ juxtafit premium afw
☐ customizable interlocking afw

Garment color
☐ beige **(default)** ☐ black

Extra Pair Undersleeves *(open ended)*:

	Lower Leg	*Whole Leg*
Beige	_____	_____
Silver	_____	_____

Extra Pair Undersocks *(close ended)*:

	Lower Leg	*Whole Leg*
Beige	_____	_____
Silver	_____	_____
Cotton Terry	_____	_____

Compressive Undersocks

15-25 mmHg	25-35 mmHg	Foot length
Small____	Small____	☐ Standard
Large____	Large____	☐ Long Foot

Cover up
☐ black ☐ beige

graduate™

	Qty Left	Qty Right	Boot style	Foam lateral rise (oblique)	Band locks	Hard sole boot	Foam liner closure	Foam liner color options
Lower leg with boot			☐ attached **(default)** ☐ separate					**Interior** ☐ beige * **Exterior** ☐ black* ☐ beige * *default*
Lower leg without boot								
Whole leg with boot			☐ attached **(default)** ☐ separate					
Whole leg without boot								
Boot only								
			Foam pad accessory: _____cm x _____cm (max. 20cm x 20cm)					

Notes on taking measurements for custom-made circaid inelastic products

• Measurements for compression garments should not be taken until the best possible decongestion effort has been achieved. Circumference and length measurements are taken in a distal to proximal sequence. Measurements should be taken with the leg extended straight, such as with a patient lying flat on a table or standing.

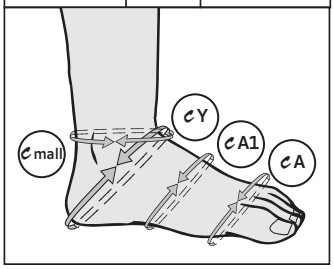
• It is essential to mark the measuring points on the leg so that the circumference and length measurements are taken at the same point.

• The circumference measurements are taken without any tension as the products are adjustable and will accommodate some changes in size. Measurements are to be taken with skin measurements. Skin measurements should be taken loosely without tension.

Patient Name: _____ Date: _____

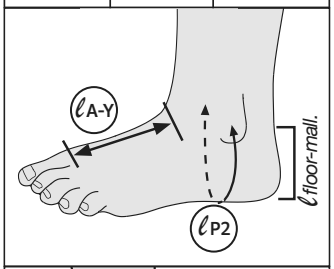
Foot measurement Circumferences

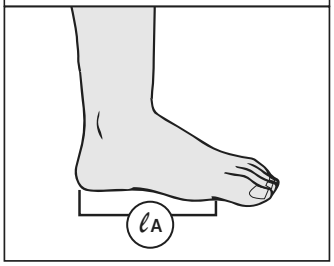
Left in cm.		Right in cm.
	c mall.	
	c y	
	c A1	
	c A	



Foot measurement Lengths

Left in cm.		Right in cm.
	ℓ P2	
	ℓ floor-mall.	
	ℓ A - Y	
	ℓ A	

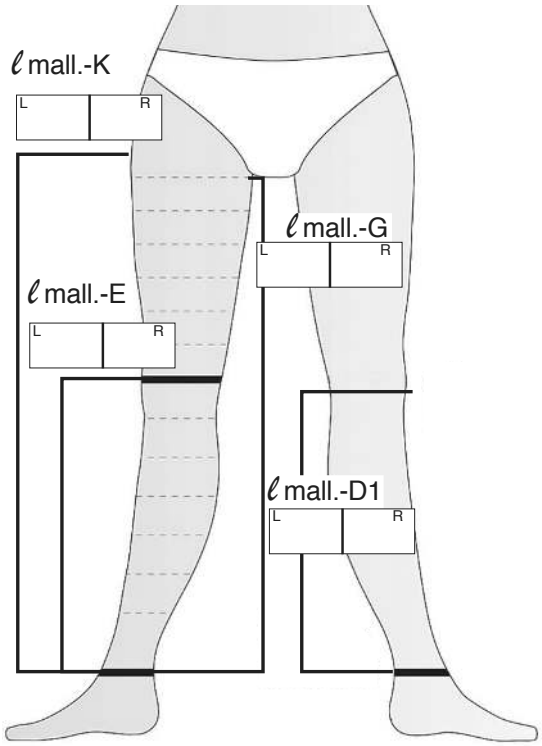




Please take measurements without tension!

Leg measurement Circumferences

Left in cm.		Right in cm.
	85	
	80	
	75	
	70	
	65	
	60	
	55	
	50	
	45	
	40	
	35	
	30	
	25	
	20	
	15	
	10	
	05	
	c mall	
	c E*	



Measurements must be every 5cm from the starting point at the malleolus.

*E = center of patella

Notes:

mediven custom circular-knit lower extremity form

medi

☐ **Exact Reorder (Order Number):** _____

Customer Name _____ Date Measured _____

Customer No. _____ Purchase Order No. _____

Patient Name _____ Measured by _____

Bill to _____

_____

Ship to _____

_____

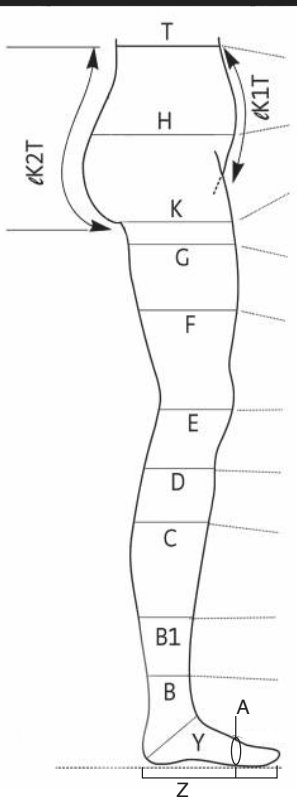
Telephone _____ Fax _____

Order Date _____ Email _____

Credit Card Info _____

Shipping Method ☐ Ground OR ☐ Express *(Express not available for chocolate and wheat color options.)*
☐ Second Day ☐ Next Day

Contact for Confirmations (select one): ☐ Email _____ ☐ Fax _____

LEFT LEG circumference	LEFT LEG length to floor	WHERE TO MEASURE	RIGHT LEG circumference	RIGHT LEG length to floor	PANTY TOP length	KEY FOR CHART
			t cm	t cm		**Height** measurement is from each marked body location to floor
			h cm	h cm	LK1T cm	**LK1T** Measurement from pubic bone to top of garment along the anatomical contour
			k cm	k cm	LK2T cm	**LK2T** Measurement from base of the gluteal fold to top of garment along the anatomical contour
g cm	g cm		g cm	g cm	Thigh	**t** Measurement at waist **h** Measurement at widest part of hips **k** Measurement around both legs at level of gluteal fold **g** Measurement at top of thigh at gluteal fold
f cm	f cm		f cm	f cm		**f** Measurement at mid thigh
e cm	e cm		e cm	e cm		**e** Measurement slightly above knee
d cm	d cm		d cm	d cm	Below Knee	**d** Measurement slightly below knee **c** Measurement at widest part of calf
c cm	c cm		c cm	c cm		**b1** Measurement between ankle and widest part of calf
b1 cm	b1 cm		b1 cm	b1 cm		**b** Measurement just above ankle bone
b cm	b cm		b cm	b cm	Thigh w/Waist Att/Maternity Panty/Men's Leotard	**y** Measurement diagonally around heel over widest part of top of ankle **a** Measurement circumference of ball of foot
y cm			y cm			**z** Measurement from heel to toe for Closed-toe stockings (enter below) **or** from heel to ball of foot for Open-toe stockings
a cm			a cm			**z Foot Requirement (choose one):** Closed-Toe: full foot length is _____cm Open-Toe: length from heel to ball of foot is _____cm

mediven®

flat-knit lower extremity & circaid® profile-Custom Order Form

medi

Customer Name _____

_____

_____

_____

Account #_____

P.O.#_____

Patient Name_____

_____

_____

Date Measured_____

Measured By_____

Exact Reorder Number_____

NPI_____

Physicians Signature_____

Physicians Signature(Printed)_____

_____

Date_____

Diagnosis: ICD-10 - check all that apply

- ☐ I89.0 Lymphedema, not elsewhere classified
- ☐ I97.2 Postmastectomy lymphedema syndrome
- ☐ I97.89Other postprocedural complications and disorders of the circulatory system, not elsewhere classified
- ☐ Q82.0 Hereditary lymphedema

Bill to: _____

_____

_____

_____

Ship to:_____

_____

_____

_____

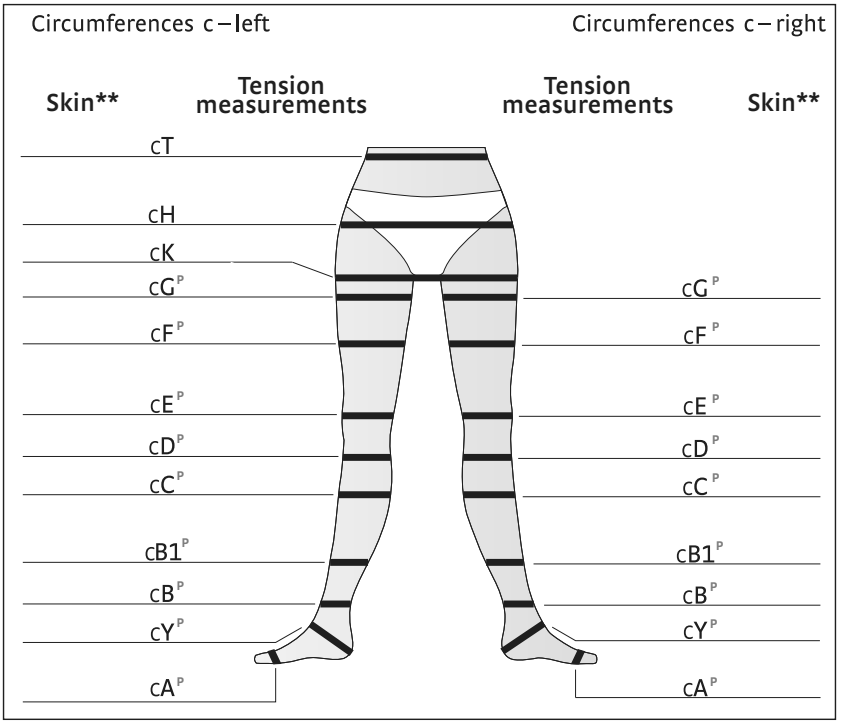
Notes: _____

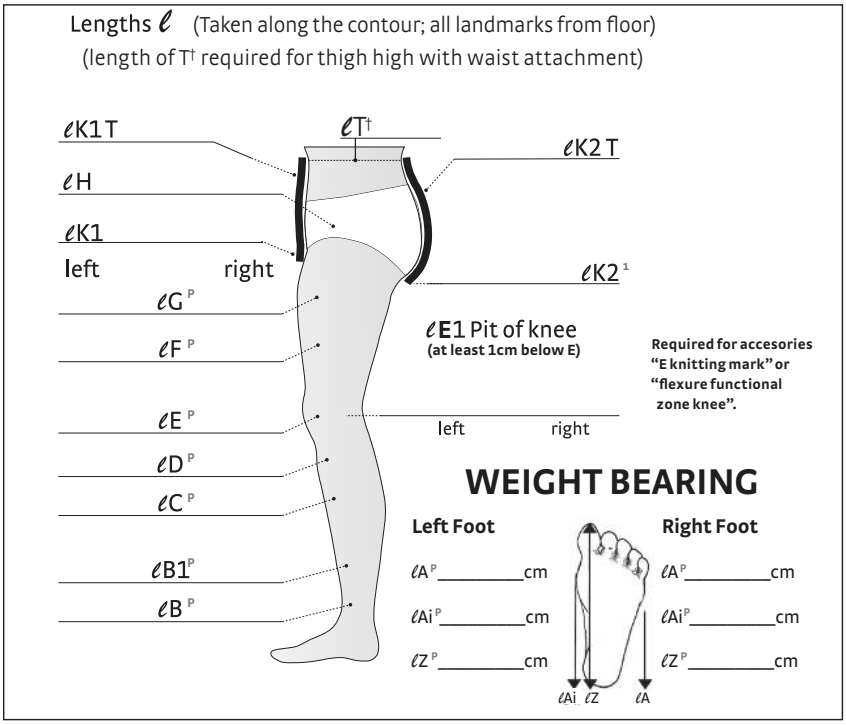
_____

_____

_____

_____





**Skin measurements optional. PMeasurement required for circaid profile
1Required for all thigh-high and above garments.

P0240 Rev T

Customer Name_____ Account #_____

Patient Name_____

Material	Compression CCL 1 2 3 4	Standard colors	Trend colors	Quantity	Foot
☐ mondi 350 (CCL 1,2,3) ☐ cosy 450 (CCL 1,2,3) ☐ mediven 550 (CCL 1,2,3,4)	Panty section ☐☐☐☐ Left leg ☐☐☐☐ Right leg ☐☐☐☐ 1 = 18-21 mmHg 2 = 23-32 mmHg 3 = 34-46 mmHg 4 = 49-60 mmHg	☐ medi Magenta* ☐ Sand ☐ Caramel ☐ Black ☐ Cashmere ☐ Navy ☐ Anthracite ☐ Grey* ☐ Chestnut*	☐ Russet-red* ☐ Light-blue* ☐ Sage-green* ☐ Lilac*	☐ Left _____ ☐ Right _____ ☐ Pair _____	☐ closed toe ☐ netting (550 only) ☐ open toe ☐ toe cap[2] (attached) ☐ varus toe ease zone (except mondi 350 or cosy lateral seam) ☐ left ☐ right ☐ hallux ease (except mondi 350) ☐ left ☐ right

Variations	Proximal border	Accessories	Waist band	
☐ below knee (AD) ☐ thigh-length (AG) (ℓK2 required) ☐ pantyhose (AT) ☐ men's leotard (ATH) ☐ maternity panty (ATU) ☐ one-legged panty (ATE) ☐ BTH/B1T/B1TH/CT/ET/FT	☐ standard oblique ☐ steep oblique ☐ straight **Lateral seam** (Not available in toe caps or waist attachment) ☐ cosy 450 ☐ mediven 550	☐ Extension to sole of foot ☐ Y knitting mark at the heel ☐ E knitting mark at the knee ☐ flexure functional zone knee (except mondi 350) ☐ extra leg length (ℓK1 needed)	☐ perforated tape (adjustable) ☐ waistband ☐ knitted border ☐ Velcro ☐ silicone dot topband ☐ Sensitive 5 cm microdot	☐ **Gusset** (women) ☐ **Suspensory** (men) _____tricot (standard) _____tricot (standard) _____netting _____netting _____compressive _____compressive length cm_____ width _____ cm ☐ Gluteal shaper (except mondi 350) Zipper from landmark_____to landmark_____ ☐ anterior ☐ posterior ☐ medial ☐ lateral

Silicone Topband

☐ wide dot 5 cm ☐ narrow dot 2.5 cm ☐ no topband
☐ Motif 5 cm beaded ☐ Sensitive 5 cm microdot ☐ Rose 5 cm solid

Other accessories

Position	Topband piece	Anti-slip dots Fixed size
☐ along the oblique border	☐ 15 x 5 cm	☐ 10 x 4.5 cm
☐ lengthways over E	☐ 8 x 5 cm	☐ 10 x 4.5 cm
☐ rear over seam	☐ 8 x 5 cm	☐ 10 x 4.5 cm
☐ on the sole	☐ 5 x 5 cm	☐ 6 x 4.5 cm

☐ silk lining material
Location:_____
(Please include drawing in Special Requests section)
width _____cm length _____cm

☐ Lymphpad
Location:_____
(Please include drawing in Special Requests section)
width _____cm length _____cm

☐ Pocket (Please specify/draw in Special Requests section)
_____ length _____ width

Silver (only mediven mondi 350) ☐ "Y" to C ☐ "Y" to D ☐ "Y" to G ☐ "A" to C ☐ "A" to D ☐ "A" to G ☐ left ☐ right

Design-Elements (single-color pattern) Not available in mondi 350 ☐ Stripes* ☐ Nature* ☐ Bloom* ☐ Wild*

Fashion-Elements (two-toned pattern) Not available in mondi 350 ☐ Stripes* ☐ Nature* ☐ Bloom* ☐ Wild*

Crystal Motifs: Location ☐ Left ankle ☐ Right ankle Pattern ☐ Proud ☐ Wind ☐ Trio
Crystal Motifs cannot be combined with Design Elements, Fashion Elements, cosy lateral seam or 550 lateral seam.

Levamed left ☐ medial ☐ lateral ☐ permanent ☐ removable
right ☐ medial ☐ lateral ☐ permanent ☐ removable

Accessories:
☐ medi Butler
☐ medi donning gloves
Other:_____

Special Requests:

circaid® profile

Style

Sleeve Length:
☐ A-G
☐ A-F
☐ A-E
☐ A-D
☐ B-G
☐ B-F
☐ B-E
☐ B-D
☐ Other
Starting landmark _____
Ending landmark _____

Side: Quantity
☐ Left: _____
☐ Right: _____

Foam:
☐ Classic Foam **(default)**
☐ Soft Foam

Thickness:
☐ Classic Channel **(default)**
☐ Slim Channel

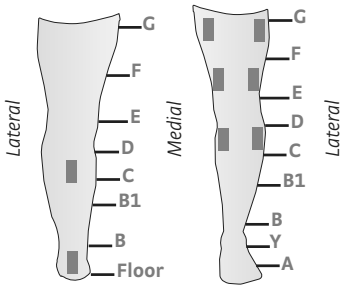
Options

Adjustable Band Type:
☐ EZ-band
☐ EZ-band lift

Adjustable Band Pull Direction:
☐ Outward **(default)**
☐ Inward (not compatible with foot, available between B and G landmarks only)

Adjustable Band Placement:
☐ Entire sleeve **(default)**
☐ Other
Starting landmark _____
Ending landmark _____
Foot Ending: ☐ Tacked **(default)** ☐ Untacked

Foam Sleeve Options:
☐ EZ-grip sole on foot
☐ Extend foot to end of toes
☐ No lateral rise at G
☐ Lateral rise at D **(5cm default)**
☐ Custom Lateral Rise
Height (0-15cm) _____ cm
☐ Extra EZ-on Tabs Quantity: _____
Mark placement of additional tabs on image, included tabs are marked.



Oversleeve

Oversleeve Color Options:
☐ No Oversleeve
☐ midnight Quantity _____
☐ magenta Quantity _____
☐ blue giraffe Quantity _____

Oversleeve Options:
☐ EZ-grip sole on foot
☐ High-energy oversleeve *(not combinable with Fused EZ-on system)*
☐ Fused EZ-on system

[2] **Toe Cap order form required. *Requires 10 additional working days for production.**

mediven®

flat-knit arm, hand & circaid profile-Custom Order Form

medi

Customer Name _____

_____

Account #_____

P.O.#_____

Patient Name_____

Date Measured_____

Measured By_____

Exact Reorder Number_____

NPI_____

Physicians Signature_____

Physicians Signature(Printed)_____

_____

Date_____

Bill to: _____

_____

_____

Ship to:_____

_____

_____

Notes: _____

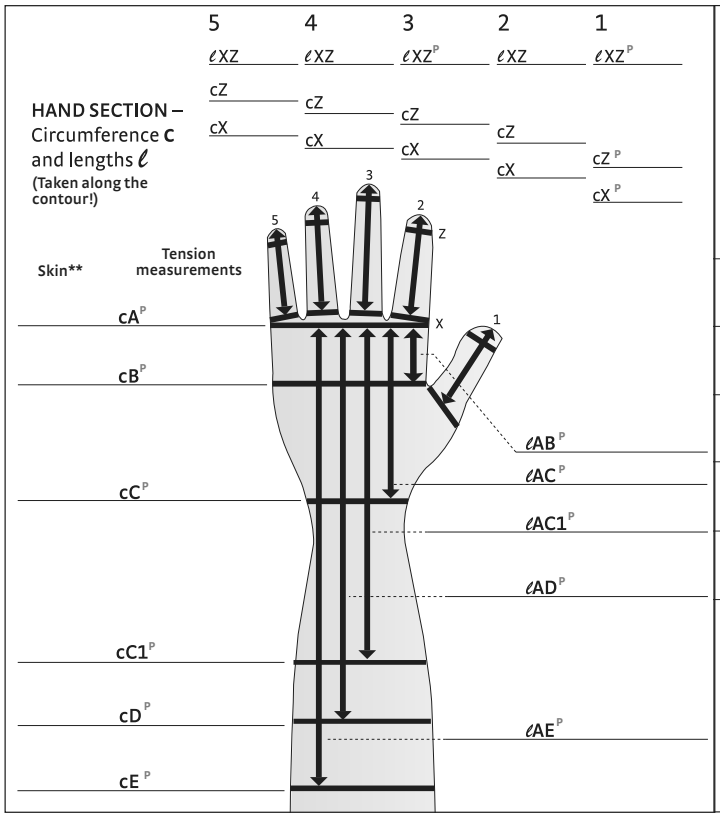
_____

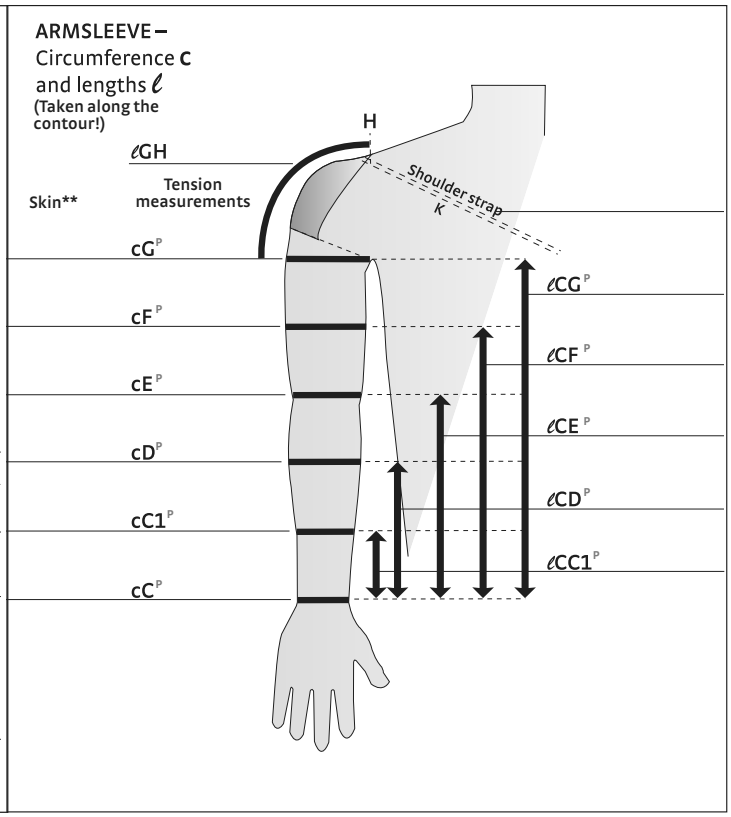
_____

Diagnosis: ICD-10 - check all that apply

- ☐ I89.0 Lymphedema, not elsewhere classified
- ☐ I97.2 Postmastectomy lymphedema syndrome
- ☐ I97.89Other postprocedural complications and disorders of the circulatory system, not elsewhere classified
- ☐ Q82.0 Hereditary lymphedema

Page 1 of 2 (remember to fax with page 2)





P0241 Rev P

P Measurement **required** for circaid profile **Skin measurements optional.

Page 1 of 2 (remember to fax with page 2)

Comfort Care Medical

SEND YOUR COMPLETED ORDER TO
Fax 443.455.1402 Email orders@comfortcaremd.com
Questions? 888.358.1580

Customer Name_____ Account #_____

Patient Name_____

mediven flat knit arm & hand

Material	Compression (CCL)	Standard Colors	Trend Colors	Qty.	Side	Handpiece
☐ mondi esprit 350 SL glove ☐ mondi esprit 350 ☐ mediven 550	CCL [1] 15-21 mmHg / CCL [2] 23-32 mmHg / CCL [3] 34-46 mmHg Hand piece ☐ ☐ ☐ Arm Sleeve ☐ ☐ ☐	☐ medi magenta* ☐ Sand ☐ Caramel ☐ Black ☐ Cashmere ☐ Navy ☐ Anthracite ☐ Grey* ☐ Chestnut*	☐ Russet-red* ☐ Light-blue* ☐ Sage-green* ☐ Lilac*	hand pcs: _____ arm pcs: _____	☐ Left ☐ Right	☐ gauntlet ☐ glove ☐ Open fingers ☐ Closed fingers

Style	Proximal Ending
Hand piece	☐ Straight (Porous 2cm) (Standard)
☐ AC1	☐ Flat oblique ☐ Steep oblique
☐ AD/AE	☐ Flat oblique (Standard) ☐ Steep oblique ☐ Straight

Style circle length choice	Proximal Ending
Armsleeve	☐ Flat oblique (Standard)
☐ CG/ CD/CE/CF CG is default	☐ Steep oblique ☐ Straight
☐ AF/AG (1-PC)	☐ Flat oblique (Standard) ☐ Steep oblique ☐ Straight

Topband

- ☐ Narrow 2.5 cm beaded
- ☐ Wide 5 cm beaded
- ☐ Sensitive 5 cm microdot
- ☐ Motif 5 cm beaded
- ☐ Rose 5 cm solid
- ☐ None

Accessories

Position	Topband Piece (sewn into the garment) Sizes	Anti-slip dots (applied directly to the garment) Fixed size
☐ Along the oblique border	☐ 5 X 2.5 cm ☐ 5 X 5 cm ☐ 5 X 10 cm ☐ 15 X 2.5 cm	☐ 6 X 4.5 cm
☐ On the palm	☐ 5 X 5 cm **Not available in mondi esprit 350 SL glove**	☐ 6 X 4.5 cm

Design Elements: (single-color pattern) Not available in mondi esprit 350 SL glove ☐ Stripes* ☐ Nature* ☐ Bloom* ☐ Wild*

Fashion Elements: (two-toned pattern) Not available in mondi esprit 350 SL glove ☐ Stripes* ☐ Nature* ☐ Bloom* ☐ Wild*

Crystal Motifs: *Location:* ☐ Lower arm ☐ Upper arm *Pattern:* ☐ Proud ☐ Wind ☐ Trio

Crystal Motifs cannot be combined with Design Elements, Fashion Elements or mondi esprit 350 SL glove.

Other Accessories

- Knitting marks at elbow: ☐ 160° (standard) ☐ 150° ☐ 135°
- ☐ Elbow flexure functional zone
- ☐ Smart-Touch **(mondi esprit 350 SL glove closed fingers only)**
- ☐ Additional porous row ending (50% COMPRESSION) _____ cm

Shoulder Attachments

- ☐ Shoulder cap standard ☐ Shoulder cap anatomical† _____ cm
- ☐ Shoulder strap width: ☐ 2.5 cm (adjustable) ☐ 5 cm (velcro)
- ☐ Bra attachment width of bra strap: _____ cm

☐ silk lining material
Location:_____
(Please include drawing in Special Requests section)

width _____cm length _____cm

☐ Lymphpad ☐ Pocket
Location:_____
(Please include drawing in Special Requests section)

width _____cm length _____cm

Only available on palm or back of hand for mondi esprit 350 SL glove.

Donning Accessories:

- ☐ medi Butler
- ☐ medi donning gloves

Other:_____

Special Requests:

circaid® profile

Style:

Sleeve length:

- ☐ A-G **(default)**
- ☐ A-C1 (gauntlet)
- ☐ C-G
- ☐ Other

Starting landmark _____
Ending landmark _____

Designed to wear together, split sleeve style.[4]

- ☐ A-C1 (glove)
- ☐ C1-G (arm sleeve)

Side: Quantity

- ☐ Left ____
- ☐ Right ____

Foam:

- ☐ Classic **(default)** Foam
- ☐ Soft Foam

Thickness:

- ☐ Classic **(default)** Channel
- ☐ Slim Channel

Options:

Adjustable Band Type:

- ☐ EZ-band
- ☐ EZ-band lift

Adjustable Band Pull Direction:

- ☐ Outward **(default)**
- ☐ Inward

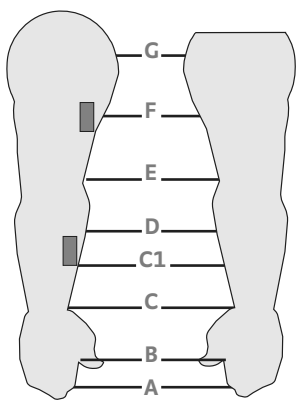
Adjustable Band Placement:

- ☐ Entire sleeve **(default)**
- ☐ Other
  Starting landmark _____
  Ending landmark _____
- ☐ Hand **(default 3 bands)**
  - ☐ Hand Band
  - ☐ Thumb Band
  - ☐ Wrist Thumb Base Band

Foam Sleeve Options:

- ☐ No thumb
- ☐ Finger foam zones
- ☐ Extended gauntlet
- ☐ Split sleeve[4]
- ☐ Custom Hand Length AB (≥3 cm) _____cm
- ☐ Custom Lateral Rise (0-15cm) _____cm
- ☐ No lateral rise
- ☐ Extra EZ-on Tabs Quantity:_____

Mark placement of additional tabs on image, included tabs are marked.



Oversleeve colors:

- ☐ No Oversleeve
- ☐ midnight Quantity _____
- ☐ magenta Quantity _____
- ☐ blue giraffe Quantity _____

Oversleeve Options:

- ☐ High-energy oversleeve[4]
- ☐ Fused EZ-on system

***Requires 10 additional working days for production. †Measure shoulder width from front to back, around the arm.**
[4] Includes Fused EZ-on system

mediven® flat-knit toe caps - Custom Order Form

medi

Customer Name _____ Account #_____

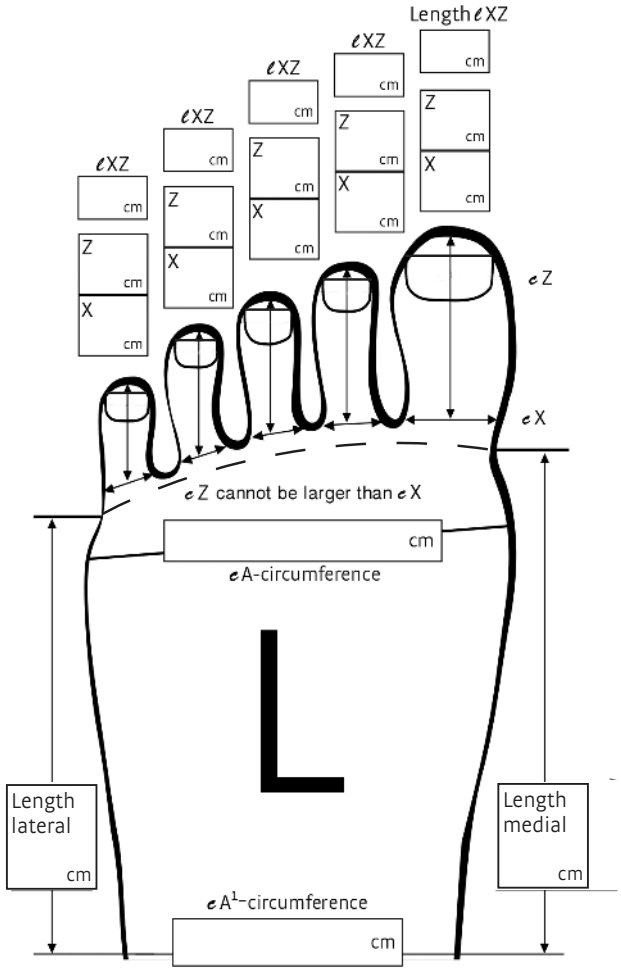
P.O.# _____ Patient Name_____Date Measured_____

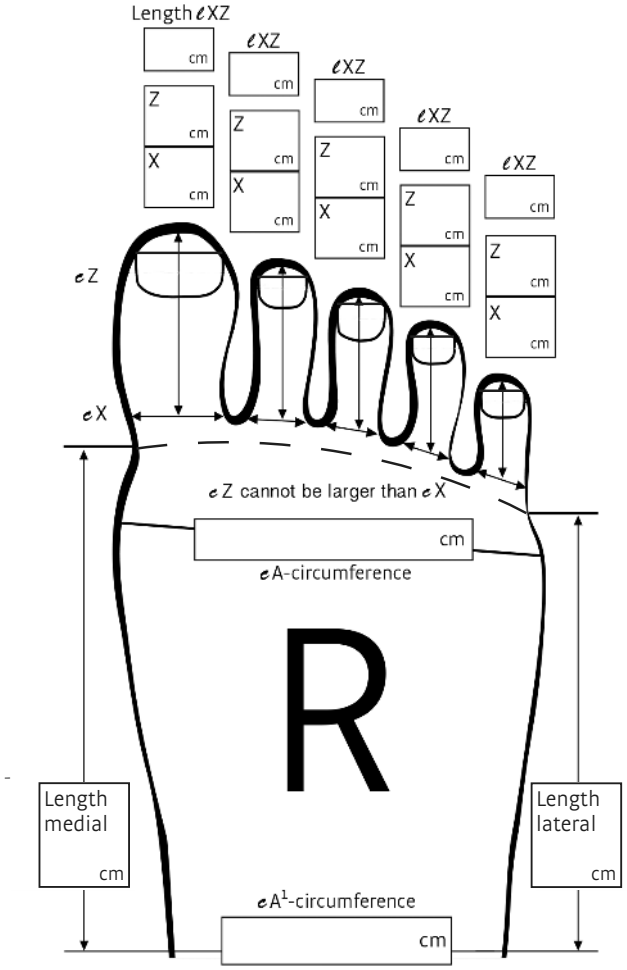
Measured By_____☐Exact Reorder Number_____

Bill to: _____ Ship to:_____

_____ _____

NPI:_____Physicians Signature:_____Printed Physicians Signature:_____Date:_____





Foot	Material
_____ Left quantity _____ Right quantity	**mediven:** ☐ 550 ☐ mondi 350 ☐ cosy 450 ☐ 550 SL (seamless)

Style (Choose One)

☐ **Attached toe cap** toe cap may be the same or lower CCL than stocking Not applicable to SL 550

☐ **Individual toe cap**

Standard Colors:

☐ medi Magenta ☐ Sand ☐ Caramel ☐ Black
☐ Cashmere ☐ Navy ☐ Anthracite ☐ Grey
☐ Chestnut*

Trend Colors:

☐ Russet-red* ☐ Light-blue* ☐ Sage-green*
☐ Lilac*

Fashion Elements (two-toned pattern) not available in mondi 350 or 550 SL

☐ Stripes* ☐ Nature* ☐ Bloom* ☐ Wild*

Design Elements (single-color pattern) not available in mondi 350 or 550 SL

☐ Stripes* ☐ Nature* ☐ Bloom* ☐ Wild*

☐ Seam on big toe side (individual toe cap only)

Compression:

☐ CCL I (18-21 mmHg)
☐ CCL II (23-32 mmHg)
☐ CCL III[1] (34-46 mmHg)

Option: (except mondi 350)

(Seamless toe cap)
☐ Hallux Ease
☐ Varus Ease

Toe Options

☐ Open Toes
☐ Closed Toes
☐ Without Small Toe

Lymphpad (Optional) Not applicable to SL 550

_____ Length (cm)
_____ Width (cm)
_____ Location

Diagnosis: ICD-10 -

check all that apply

☐ I89.0 Lymphedema, not elsewhere classified

☐ I97.2 Postmastectomy lymphedema syndrome

☐ I97.89 Other postprocedural complications and disorders of the circulatory system, not elsewhere classified

☐ Q82.0 Hereditary lymphedema

*Requires 10 additional working days for production.

[1]550 only

P0242 Rev Q

JOBST® FarrowWrap® Custom Lower Extremity

Patient Name / BSN File # _____ DOB_____ Date_____

Address _____ Gender M ☐ F ☐

City / State / Zip_____

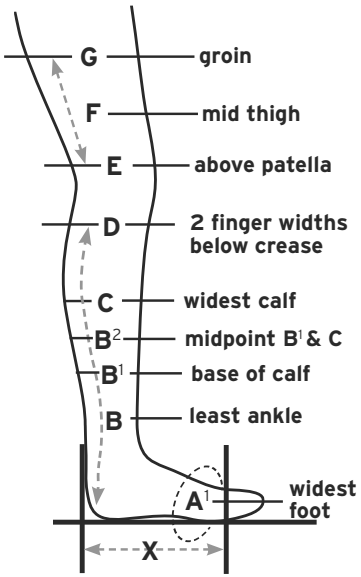
Diagnosis_____

Doctor / Address_____

City / State / Zip_____

PO#

Original Order ☐ Reorder w Changes ☐
Exact Reorder ☐ _____



CIRCUMFERENCE (C)	LEFT	RIGHT
c**G** (groin)		
c**F** (mid thigh)		
c**E** (above patella)		
c**D** (2 finger widths below crease)		
c**C** (widest calf)		
c**B**[2] (midway between cB[1] and cC)		
c**B**[1] (base of calf)		
c**B** (smallest point above ankle)		
c**A**[1] (widest foot)		

LENGTH	LEFT	RIGHT
*l***E-G** (medially)		
*l***A-D** (posteriorly, follow contour)		
*l***X** (from base of toes to heel)		

Base of small toe to heel.

JOBST® FARROWWRAP® LINERS

BSN Code	Description	Quantity
7666800	Farrow Standard AD Liners Small (Leg Circumference < 56cm)	
7666802	Farrow Standard AD Liners Large (Leg Circumference 53-70cm)	
7666900	Farrow TG® Soft AD Liners (S < 40cm)	
7666902	Farrow TG® Soft AD Liners (M 40-70cm)	
7666904	Farrow TG® Soft AD Liners (L > 70cm)	
7667000	Farrow TG® Soft AG Liners (S < 40cm)	
7667002	Farrow TG® Soft AG Liners (M 40-70cm)	
7667004	Farrow TG® Soft AG Liners (L > 70cm)	

BRAND / COMPRESSION	QUANTITY	ADDITIONAL LINERS (additional charge, ordered in pairs)
☐ LITE (20-30mmHg) ☐ CLASSIC (30-40mmHg) ☐ STRONG (30-40mmHg)	Thigh: Left _____ Right _____ Leg: Left _____ Right _____ Foot: Left _____ Right _____ Knee:* Left _____ Right _____ *(only available in Lite and Strong.)	Liner model: ☐ TG Soft ☐ Standard Size: ☐ Small ☐ Medium ☐ Large

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TO ORDER:

JOBST® FarrowWrap® Upper Extremity

Ready-To-Wear • Custom • Trim-to-Fit

Patient Name / BSN File # _____ DOB_____ Date_____

Address _____ Gender M ☐ F ☐

City / State / Zip_____

Diagnosis_____

Doctor / Address_____

City / State / Zip_____

PO#

Original Order ☐ Reorder w Changes
Exact Reorder ☐ _____

Ready-To-Wear Arm

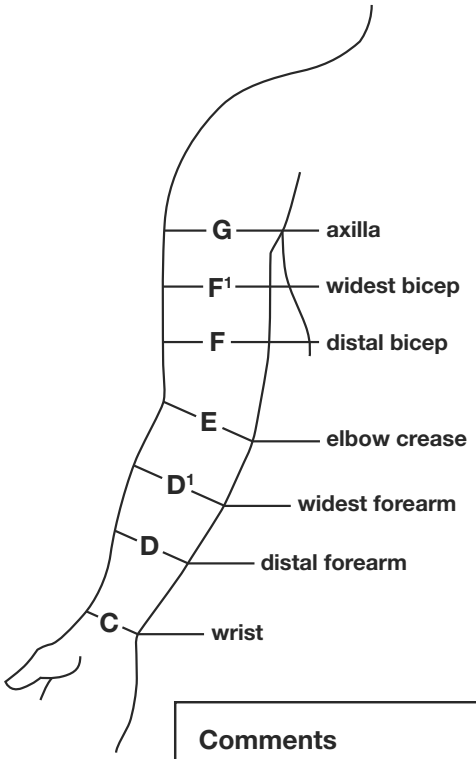
Fabric
☐ LITE
Color
☐ Beige (00)
☐ Black (01)
Length
☐ Short (S)
☐ Regular (R)
☐ Long (L)
Size
☐ Small (2)
☐ Medium (3)
☐ Large (4)
Side
☐ Left (L)
☐ Right (R)

Custom

Style
☐ Custom
Fabric
☐ Classic
☐ LITE
☐ STRONG
Color
☐ Tan
Side
☐ Left (L)
☐ Right (R)

Trim-To-Fit

Size
☐ Medium (3)
☐ Extra Large (5)
Side
☐ Left (L)
☐ Right (R)



Circumference (c)	Left	Right
cG (axilla)*		
cF[1] (widest bicep)		
cF (distal bicep)		
cE (elbow crease)*		
cD[1] (widest forearm)		
cD (distal forearm)		
cC (wrist)*		

Lengths	Left	Right
lC-G (wrist to axilla)*		
lC-E (wrist to elbow)		

Comments

_____

_____

_____

*Circumference measurements needed for Ready to Wear garments.
Please note that all measurements are needed for Custom garments.

JOBST® FarrowWrap® Upper Extremity

Ready-To-Wear • Custom • Trim-to-Fit

READY-TO-WEAR ARM

Size	Wrist (cC)	Elbow (cE)	Axilla (cG)
S	14-18 cm	20-27 cm	22-31 cm
M	16-21 cm	25-34 cm	29-39 cm
L	19-25 cm	30-40 cm	32-45 cm
Length (C-G)	Short 40-43 cm		
	Regular 44-47 cm		
	Long 48-51 cm		

TRIM-TO-FIT ARM

Size	Wrist (cC)	Forearm (cD)	Elbow (cE)	Bicep (cF)	Axilla (cG)	Length (C-E)	Length (E-G)
M	15-31 cm	20-36 cm	20-38 cm	25-42 cm	25-44 cm	20-25 cm	15-23 cm
XL	15-35 cm	20-40 cm	25-42 cm	25-45 cm	30-48 cm	20-28 cm	

READY-TO-WEAR ARM - TAN

BNR	Description	Quantity
7665035	LITE Armpiece Long Small Left Tan	
7665000	LITE Armpiece Long Small Right Tan	
7665001	LITE Armpiece Long Medium Left Tan	
7665002	LITE Armpiece Long Medium Right Tan	
7665003	LITE Armpiece Long Large Left Tan	
7665004	LITE Armpiece Long Large Right Tan	
7665005	LITE Armpiece Regular Tan Small Left	
7665006	LITE Armpiece Regular Tan Small Right	
7665007	LITE Armpiece Regular Tan Medium Left	
7665008	LITE Armpiece Regular Tan Medium Right	
7665009	LITE Armpiece Regular Tan Large Left	
7665010	LITE Armpiece Regular Tan Large Right	
7665011	LITE Armpiece Short Tan Small Left	
7665012	LITE Armpiece Short Tan Small Right	
7665013	LITE Armpiece Short Tan Medium Left	
7665014	LITE Armpiece Short Tan Medium Right	
7665015	LITE Armpiece Short Tan Large Left	
7665016	LITE Armpiece Short Tan Large Right	

READY-TO-WEAR ARM - BLACK

BNR	Description	Quantity
7665023	LITE Armpiece Regular Black Small Left	
7665024	LITE Armpiece Regular Black Small Right	
7665025	LITE Armpiece Regular Black Medium Left	
7665026	LITE Armpiece Regular Black Medium Right	
7665027	LITE Armpiece Regular Black Large Left	
7665028	LITE Armpiece Regular Black Large Right	
7665029	LITE Armpiece Short Black Small Left	
7665030	LITE Armpiece Short Black Small Right	
7665031	LITE Armpiece Short Black Medium Left	
7665032	LITE Armpiece Short Black Medium Right	
7665033	LITE Armpiece Short Black Large Left	
7665034	LITE Armpiece Short Black Large Right	
7665017	LITE Armpiece Long Black Small Left	
7665018	LITE Armpiece Long Black Small Right	
7665019	LITE Armpiece Long Black Medium Left	
7665020	LITE Armpiece Long Black Medium Right	
7665021	LITE Armpiece Long Black Large Left	
7665022	LITE Armpiece Long Black Large Right	

CUSTOM CLASSIC

BNR	Description	Quantity
7599500	Classic Arm	

CUSTOM STRONG

BNR	Description	Quantity
7598700	STRONG Arm	

CUSTOM LITE

BNR	Description	Quantity
7599100	LITE Custom Arm (Left or Right)	

FARROWWRAP TRIM-TO-FIT

BNR	Description	Quantity
7612000	LITE Armpiece (Left) Medium with 1 pair of arm liners	
7612002	LITE Armpiece (Right) Medium with 1 pair of arm liners	
7612001	LITE Armpiece (Left) Extra Large with 1 pair of arm liners	
7612003	LITE Armpiece (Right) Extra Large with 1 pair of arm liners	

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JOBST® FarrowWrap®

TOE CAP ORDER FORM

FAX ORDER TO CUSTOMER SERVICE AT:

Date:_____ Purchase Order No.:_____ Account No.:_____

☐ Credit Card On File – Last 4 Numbers:_____ Or ☐ New Card – Call Us To Provide Credit Card Number

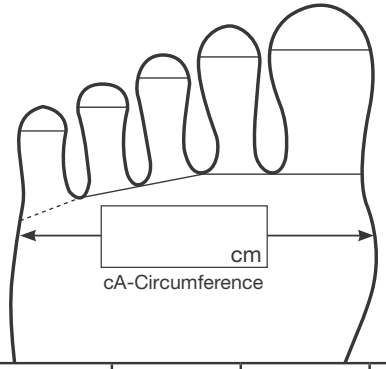
Fitter:_____ Patient Name:_____

Address:_____ Bill To Address:_____

Ship To:_____ Phone:_____

Fax:_____ E-mail:_____

☐ By choosing communication via email (above), I acknowledge that Personal Health Information associated with this purchase may be transmitted from BSN in a non-encrypted manner.



Size	X-Small	Small	Medium	Large
cA	20-22 cm	22-24 cm	24-26 cm	26-28 cm

JOBST® FARROWWRAP® TOE CAP

BSN Code	Size	Color	Compression Class	Quantity
7102700	X-Small	Tan	15-20 mmHg	
7102701	Small	Tan	15-20 mmHg	
7102702	Medium	Tan	15-20 mmHg	
7102703	Large	Tan	15-20 mmHg	
7294700	X-Small	Tan	20-30 mmHg	
7294701	Small	Tan	20-30 mmHg	
7294702	Medium	Tan	20-30 mmHg	
7294703	Large	Tan	20-30 mmHg	
7102704	X-Small	Black	15-20 mmHg	
7102705	Small	Black	15-20 mmHg	
7102706	Medium	Black	15-20 mmHg	
7102707	Large	Black	15-20 mmHg	
7294704	X-Small	Black	20-30 mmHg	
7294705	Small	Black	20-30 mmHg	
7294706	Medium	Black	20-30 mmHg	
7294707	Large	Black	20-30 mmHg	

* The mean compression for an average foot size.
Please refer to the product label and / or package insert for full instructions on the safe use of these products.

BSN Medical Inc., an Essity company
5825 Carnegie Blvd. Charlotte. NC 28209-4633 Tel.

63232 R3 ©2025 Essity HMS North America Inc. F25

JOBST FarrowWrap®

GAUNTLET ORDER FORM

FAX ORDER TO CUSTOMER SERVICE AT:

Date:_____ Purchase Order No.:_____ Account No.:_____

☐ Credit Card On File – Last 4 Numbers:_____ Or ☐ New Card – Call Us To Provide Credit Card Number

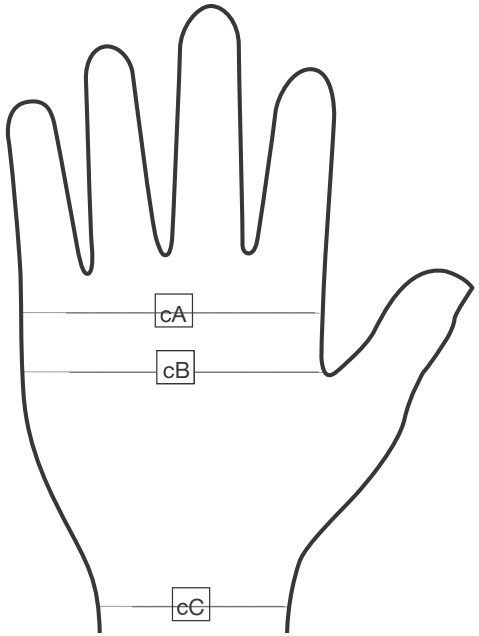
Fitter:_____ Patient Name:_____

Address:_____ Bill To Address:_____

Ship To:_____ Phone:_____

Fax:_____ E-mail:_____

☐ By choosing communication via email (above), I acknowledge that Personal Health Information associated with this purchase may be transmitted from BSN in a non-encrypted manner.



JOBST® FARROWWRAP® Lite Hand Gauntlet

Size	cA	cB	cC
XS	16-18 cm	17-19 cm	15-18 cm
SM	18-20 cm	19-21 cm	17-20 cm
MD	20-22 cm	21-23 cm	19-22 cm
LG	22-24 cm	23-26 cm	22-24 cm

JOBST® FARROWWRAP® GAUNTLET

BNR	Size	Color	Compression Class	Quantity
7665300	XS	Tan	20-30 mmHg	
7665301	SM	Tan	20-30 mmHg	
7665302	MD	Tan	20-30 mmHg	
7665303	LG	Tan	20-30 mmHg	

* The mean compression for an average foot size.
Please refer to the product label and / or package insert for full instructions on the safe use of these products.

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5825 Carnegie Blvd. Charlotte. NC 28209-4633 Tel.

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LEFT FOOT OUTLINE

FOR USE WHEN ORDERING JOBST® OPEN OR CLOSED TOE GARMENTS

(For Right Foot, see other side)

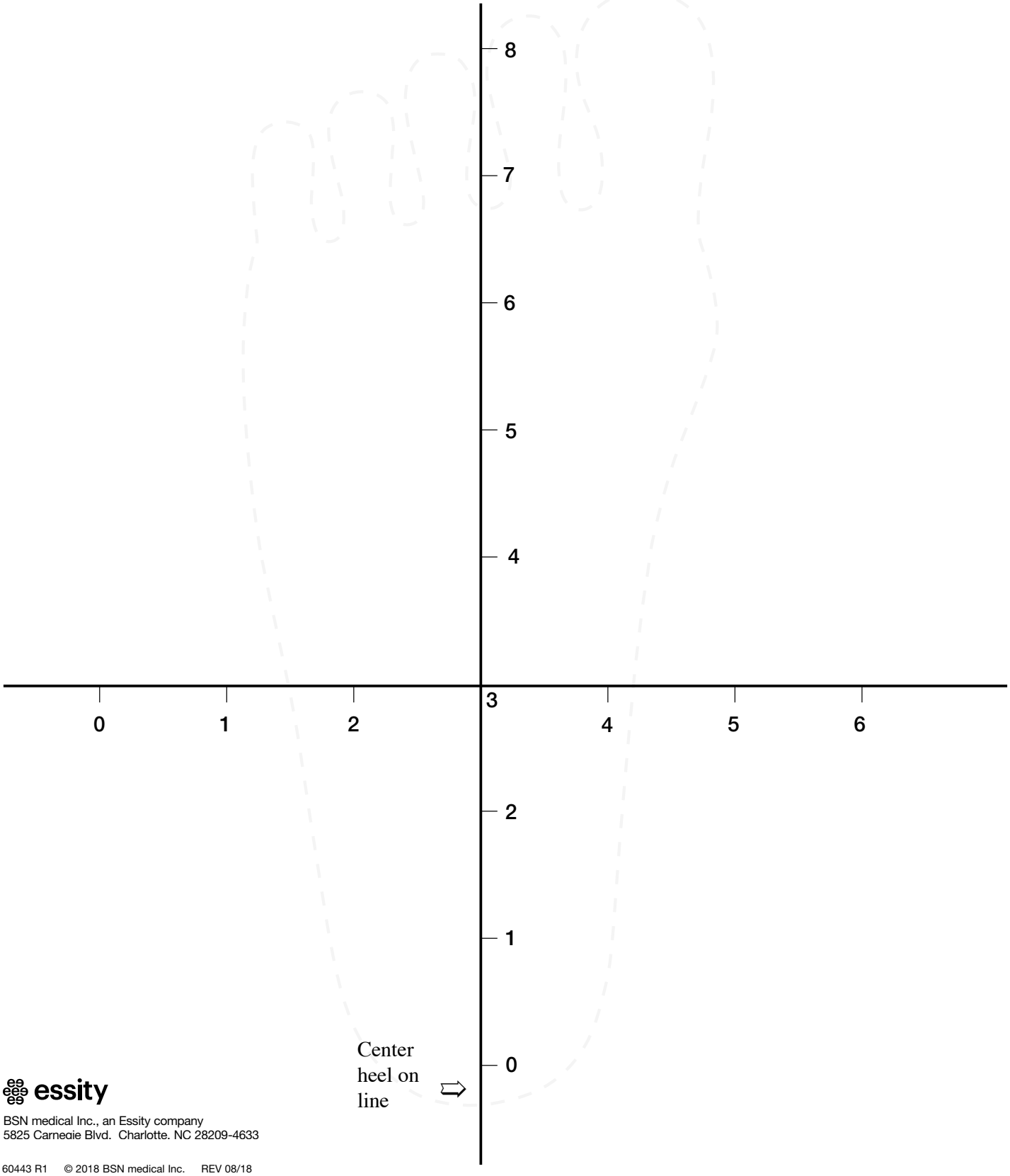
Patient Name: _____

File#:_____

Acct. #:_____ Date: _____

Measured By:_____

INSTRUCTIONS:
1) Place heel on center line.
2) Use black pen.
3) Fax or mail outline with order.
4) Do not copy form. Additional forms are available by calling



essity

BSN medical Inc., an Essity company
5825 Carnegie Blvd. Charlotte. NC 28209-4633

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RIGHT FOOT OUTLINE

FOR USE WHEN ORDERING JOBST® OPEN OR CLOSED TOE GARMENTS

(For Left Foot, see other side)

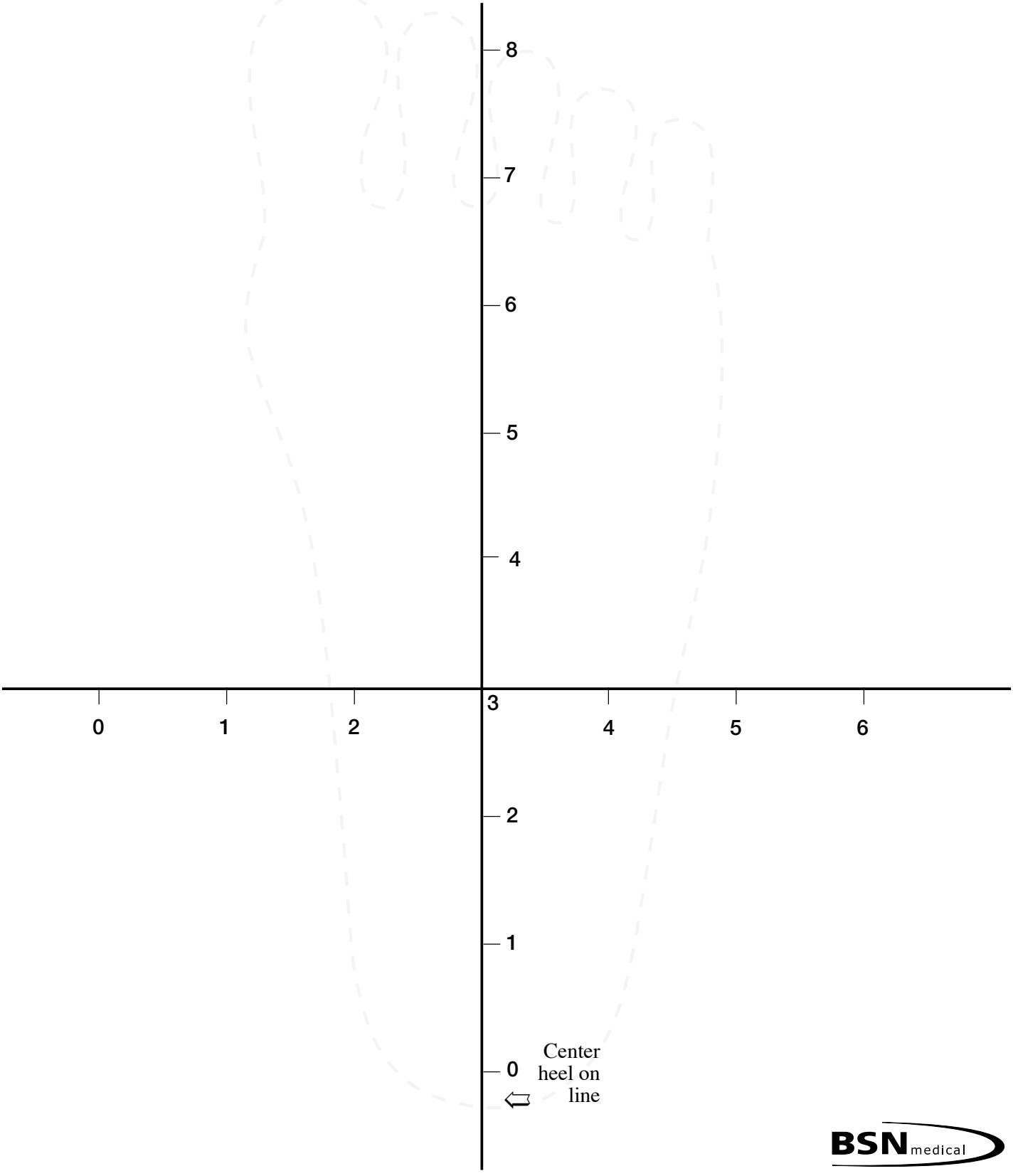
INSTRUCTIONS:
1) Place heel on center line.
2) Use black pen.
3) Fax or mail outline with order.
4) Do not copy form. Additional forms are available by calling

Patient Name: _____

File#:_____

Acct. #:_____ Date: _____

Measured By:_____



BSN medical

LEFT HAND OUTLINE

FOR USE WHEN ORDERING JOBST® GLOVES

(For Right Hand, see other side)

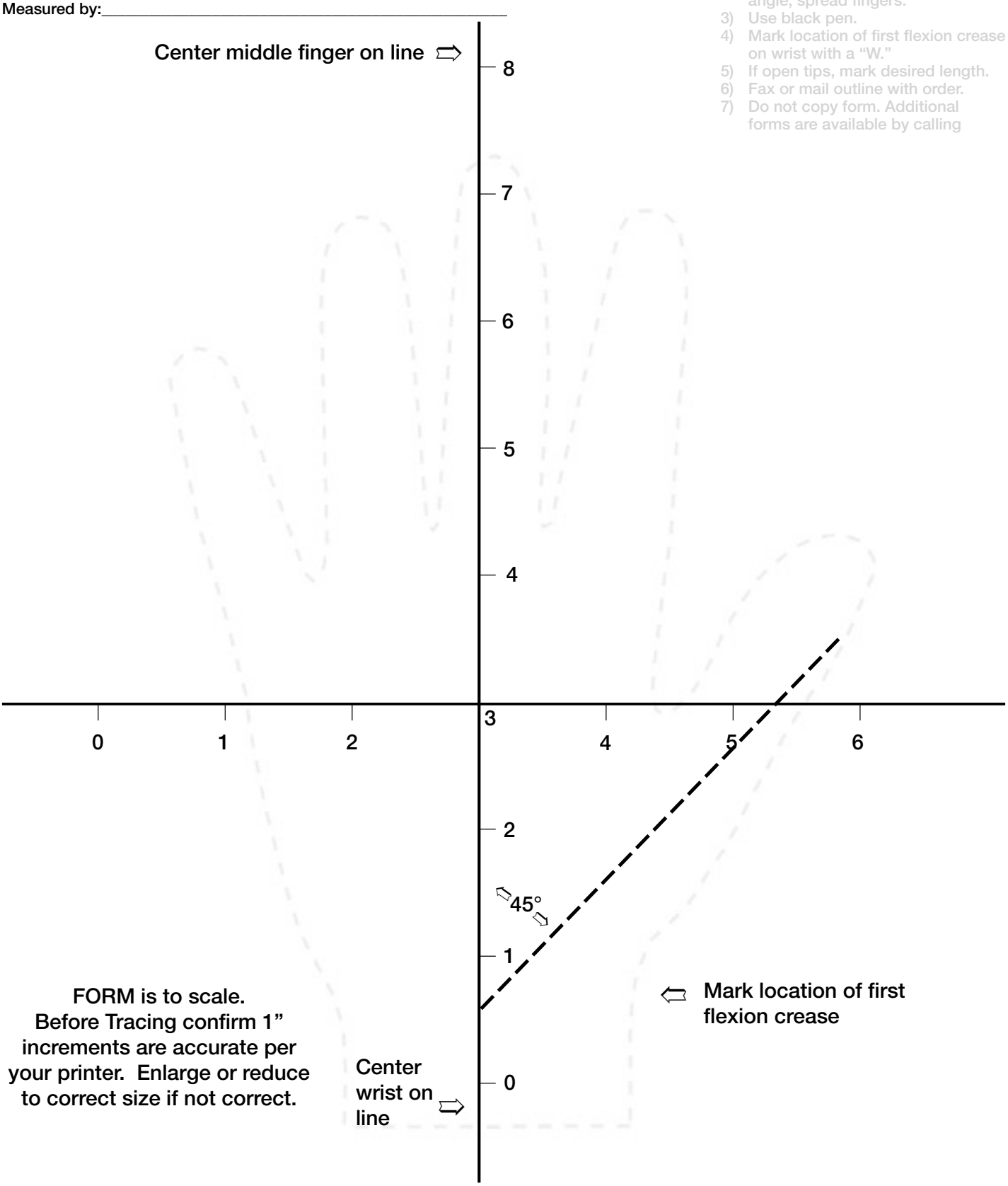
Patient Name: _____

File#:_____

Acct. #:_____ Date: _____

Measured by:_____

INSTRUCTIONS:
1) Place middle finger and wrist on center line.
2) Place palm flat, thumb at 45° angle, spread fingers.
3) Use black pen.
4) Mark location of first flexion crease on wrist with a "W."
5) If open tips, mark desired length.
6) Fax or mail outline with order.
7) Do not copy form. Additional forms are available by calling



FORM is to scale. Before Tracing confirm 1" increments are accurate per your printer. Enlarge or reduce to correct size if not correct.

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RIGHT HAND OUTLINE

FOR USE WHEN ORDERING JOBST® GLOVES

(For Left Hand, see other side)

INSTRUCTIONS:

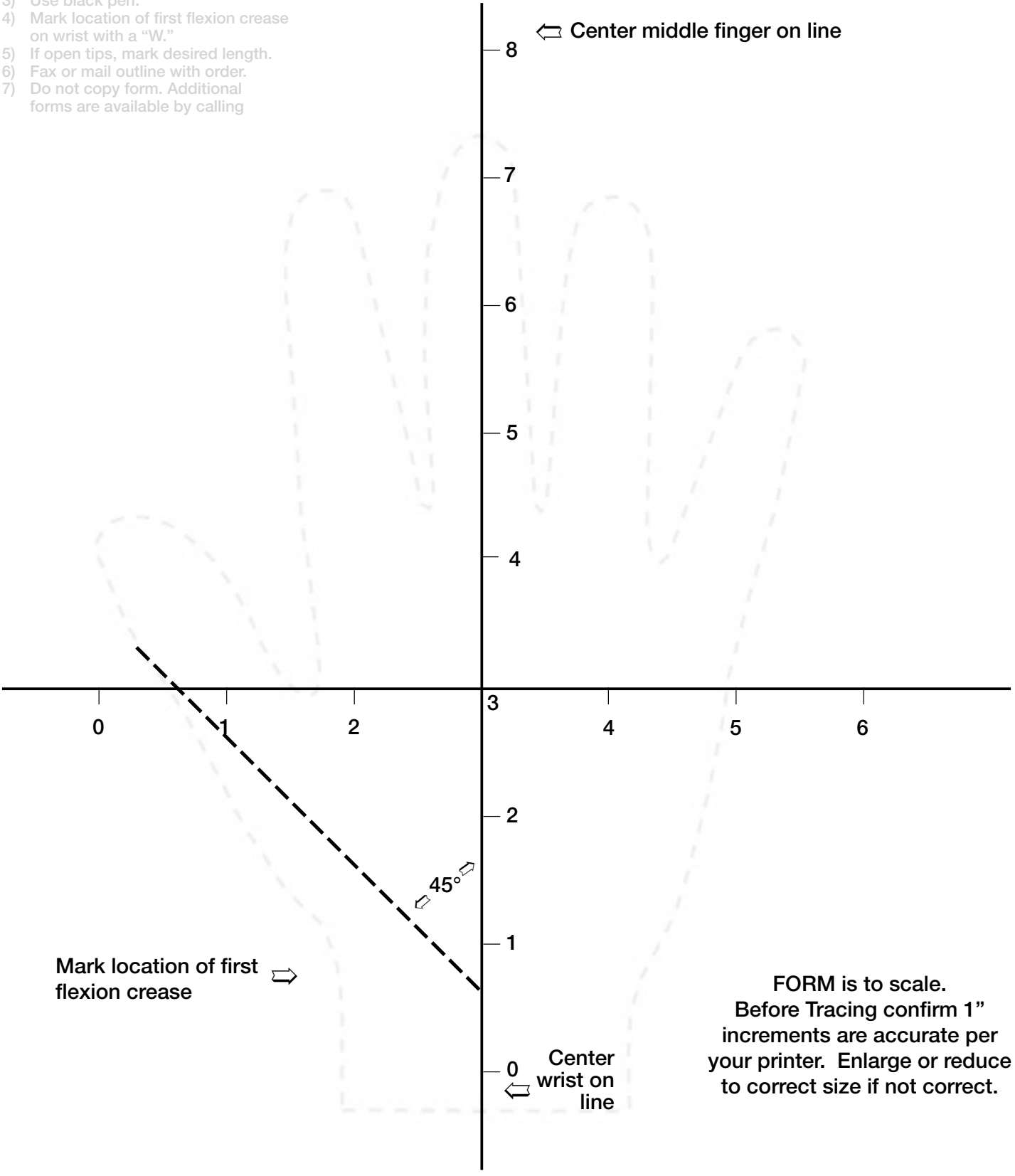
1) Place middle finger and wrist on center line.
2) Place palm flat, thumb at 45° angle, spread fingers.
3) Use black pen.
4) Mark location of first flexion crease on wrist with a "W."
5) If open tips, mark desired length.
6) Fax or mail outline with order.
7) Do not copy form. Additional forms are available by calling

Patient Name: _____

File#:_____

Acct. #:_____ Date: _____

Measured by:_____



FORM is to scale. Before Tracing confirm 1" increments are accurate per your printer. Enlarge or reduce to correct size if not correct.

JOBST® Custom Seamed

VEST FORM (No Bra Cups)

Date:_____ Purchase Order No.:_____ Fitter.:_____

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

Address _____

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

Account No.:_____

Ship To Address:_____

Bill To Address:_____

☐ Prepaid ☐ Invoice ☐ Same as Ship To

* By choosing communication via email (above), I acknowledge that Personal Health Information associated with this purchase may be transmitted from BSN in a non-encrypted manner.

DIAGNOSIS: Please Check Appropriate Box(es)

☐ Edema
☐ Lymphedema
☐ Orthostatic Hypotension
☐ Thrombotic Syndrome
☐ Sclerotherapy / Vein Ligation
☐ Venous Ulcer
☐ Varicose Veins
☐ Venous Insufficiency
☐ Arterial Insufficiency
☐ Other:

_____

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		

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JOBST® Custom Seamed

VEST FORM (No Bra Cups)

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 PLE AT				+18				AXILLA PLEAT
				+19½				

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JOBST® Custom™ Seamed Order Form

1 DATE: _____

- ☐ ORIGINAL ORDER
- ☐ REORDER
- ☐ QUOTE ONLY

RUSH Order with charge:

- ☐ **yes**

2 **GENDER:**

- ☐ MALE
- ☐ FEMALE

3 **DIAGNOSIS:** Please Check Appropriate Box(es)

- ☐ Edema
- ☐ Lymphedema
- ☐ Orthostatic Hypotension
- ☐ Thrombotic Syndrome
- ☐ Sclerotherapy/ Vein Ligation
- ☐ Other: List _____
- ☐ Venous Ulcer
- ☐ Varicose Veins
- ☐ Venous Insufficiency
- ☐ Arterial Insufficiency

4 **REQUIRED**

- ☐ 15-20 mmHg
- ☐ 20-30 mmHg
- ☐ 30-40 mmHg
- ☐ 40-50 mmHg
- ☐ Other: _____

5 **REQUIRED:** Date of Birth ____/____ (Month / Year)

PATIENT NAME _____ (Last Name First) Patient File Number _____

Optional

Address _____

_____

_____

Phone # ( ) _____

6 DEALER / CLINIC / PRESCRIBER / HOSPITAL _____

Phone # ( ) _____ **Facility Account #** _____

Order confirmation: Fax No. _____ or E-Mail address _____

Measured By: _____ Fitter # _____

7 SHIP TO _____ **Facility Account #** _____

Address _____

Cannot ship to a PO Box _____

_____

_____

Attention _____

8 BILL TO _____ **Facility Account #** _____

Address _____

☐ **Prepaid** _____ Same as ☐ ☐

☐ **Invoice** _____

Attention _____ P.O. No. _____

9 ☐ VISA ☐ MC ☐ AMEX Expiration Date _____ Auth.# _____

Card Number _____ Card Name _____

Federal Law (USA) restricts the device to the sale by or on the order of a physician.

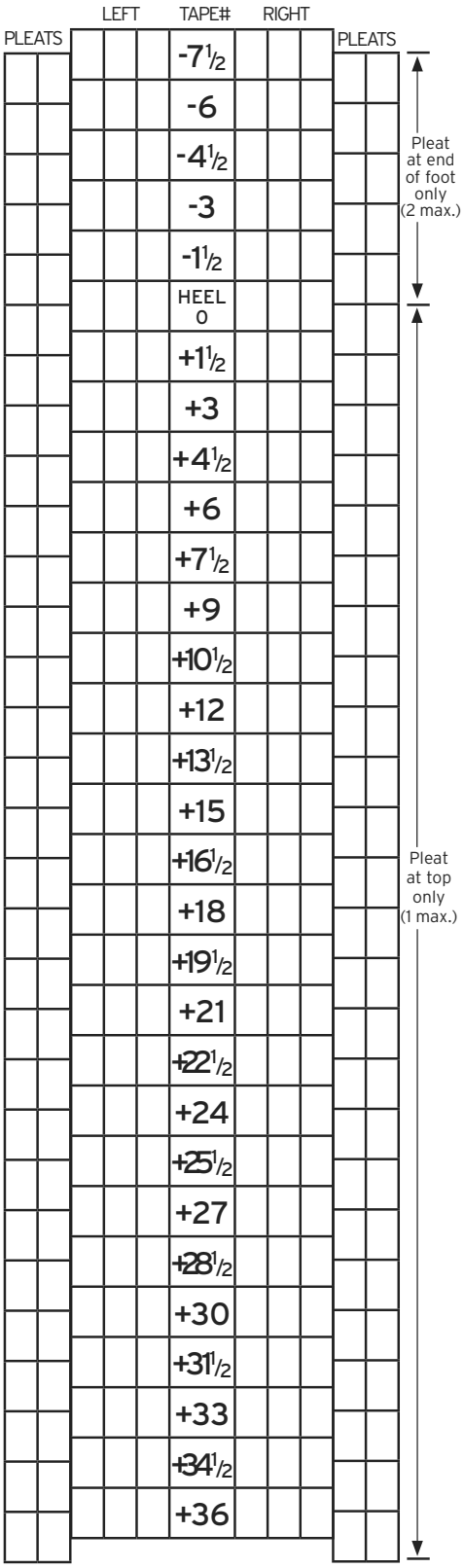
Please enter comments on page 6

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CUSTOM SEAMED – LOWER EXTREMITIES

10 LEG CIRCUMFERENCE

PATIENT'S NAME and/or FILE # _____



11 STYLES / OPTIONS / COLORS

CAT. NO.	STYLES	QTY. LEFT	QTY. RIGHT	QTY. OTHER	PRICE EACH
100105	Anklet				
100101	Knee Length				
100201	Thigh Length				
100019	Leg Band (Knee or Thigh)				
100538	Foot Glove to Ankle Length				
100539	Foot Glove Extending to Knee Length				
Waist Height: See Box #22 for Body Measurements					
101101	Waist Height / Two Legs / Closed Pubis				
101102	Waist Height / Two Legs / Open Pubis				
101103	Waist Height / One Leg / Open Pubis				
101112	Waist Height / One Leg Panty, Open Pubis				
101113	Waist Height / One Leg Panty, Closed Pubis				
101114	Waist Height / One Leg, Brief				
101119	Panty Girdle / Two Legs, Above Knee, Closed Pubis				
101111	Panty Girdle / Two Legs, Below Knee, Closed Pubis				
101122	Panty Girdle / Two Legs, Above Knee, Open Pubis				
101110	Panty Girdle / Two Legs, Below Knee, Open Pubis				
100035	Chap Style / One Leg				
100036	Chap Style / Two Legs				
Colors					
100150	Beige				
100158	Black				
Options					
101187	Reinforced Heel (per Leg)				
101188	Full Ankle Lining (including Heel) (per Leg)				
101186	Reinforced Knee				
100040	Lining Behind Knee (per Leg)				
101159	Self-material Enclosed Toe (see box 12)				
101160	Soft Enclosed Toe				
101164	Zippers (see box 13)				
101108	Zipper Pull (Plastic)				
101178	Lining Variation				
100027	Pocket				
101117	2" Elastic				
100161	2" Custom Sensitive Silicone				
101121	Abdominal Pelvic Support				
101161	Reduced Pressure Abdominal Panel				
101162	Attached Suspenders (under age 6, no charge)				
101185	Reinforced Inner Thigh & Perineum				
101177	Oversize Charge (50" to 59 ⅛")				
100031	Oversize Charge (60" to 69 ⅛")				
100042	Oversize Charge (70" or greater)				
101118	1" Silicone Band				
100160	2" Silicone Band				
101163	1" Velcro® Tabs (Waist height only)				
101176	Contracture Seam				
Stumps					
100039	Stump Support, One Stump and Panty				
100037	Chap Style, One Stump				
100038	Chap Style, Two Stump				

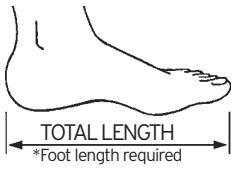
Please enter comments on page 6

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CUSTOM SEAMED – FOOT / TORSO

PATIENT'S NAME and/or FILE # _____

12 FOOT MEASUREMENTS



LEFT		
RIGHT		

13 ZIPPER OPTIONS

	LOCATION MARK (D) LEFT	LOCATION MARK (D) RIGHT	LENGTH IN INCHES LEFT	LENGTH IN INCHES RIGHT
LATERAL (outside) ASPECT (standard)				
MEDIAL (Inside) ASPECT				
IN BODY ONLY (waist height only)				

Zipper through top support ☐ YES ☐ No

14 STYLES

CAT. NO.	STYLES	QTY.	PRICE EACH
100525	Sleeveless Vest 1, 10-14, 17		
100524	Vest 1 Long Sleeve 1 Short Sleeve 1, 10-14, 17 + arm(s)		
100526	Vest - 2 Short Sleeves 1, 10-14, 17 + arm(s)		
100527	Vest - 2 Long Sleeves 1, 10-14, 17 + arm(s)		
100530	Sleeveless Body Brief 1, 5, 7, 9-17		
100531	Body Brief with Sleeves 1, 5, 7, 9-17 + arm(s)		
100558	Sleeveless Body Suit 1, 5, 7, 9-17 + **leg(s)**		
100560	Body Suit with Sleeves 1, 5, 7, 9-17 + arm(s) & **leg(s)**		
101117	2" Elastic		
100161	2" Custom Sensitive Silicone		
100027	Pocket		
101178	Lining Variation		
101118	1" Silicone Elastic (Beaded Dot Silicone band)		
100160	2" Silicone Elastic (Beaded Dot Silicone band)		
100150	Beige		
100158	Black		

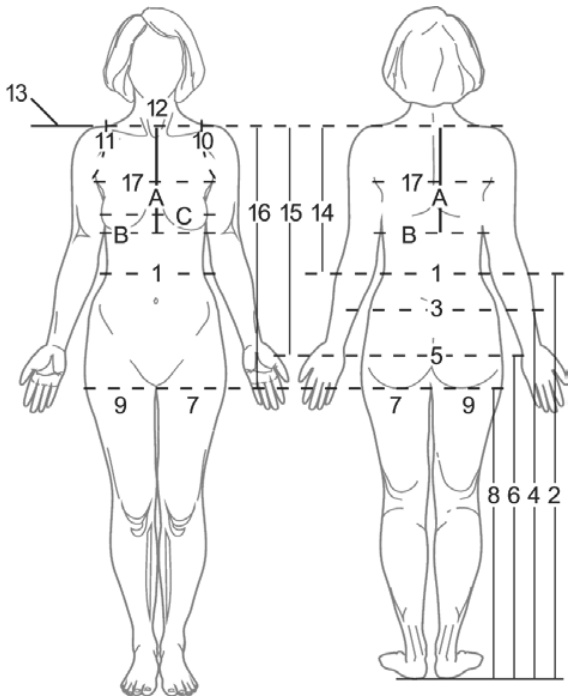
If arm or leg measurements are required go to arm or lower extremity section(s).

15 CIRCUMFERENCES

	CIRCUM			HEIGHT		
Desired Top of Support						
Waist	1			2		
Midpoint Between 1 & 5	3			4		
Largest Part of Buttocks	5			6		
Proximal Thigh Left (at fold of buttocks)	7			8		
Proximal Thigh Right (at fold of buttocks)	9			8		
Left Shoulder	10					
Right Shoulder	11					
Neck	12					
Shoulder Width				13		
Shoulder to Waist				14		
Shoulder to Largest Part of Buttocks				15		
Shoulder to Fold of Buttocks				16		
Chest	17					
End of Support						
Shoulder to End of Support						
Circumference at End of Support						
Measurement for Bra Cups						
Shoulder to Just Under Breast	A					
Circumference Just Under Breast	B					
Circumference Over Nipple Line	C					

16 TORSO / BODY DESIGN CHOICES

	Front Closure Zipper	Front Closure Velcro	Back Closure Zipper	Back Closure Velcro	Open Axilla LT RT	Self Axilla LT RT	V Neck	Turtle-neck	Scoop Neck
✔ IF YES	☐	☐	☐	☐	☐	☐	☐	☐	☐



Please enter comments on page 6

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CUSTOM SEAMED – ARM

PATIENT'S NAME and/or FILE # _____

17 STYLES / OPTIONS

CAT. NO.	STYLES	QTY. LEFT	QTY. RIGHT	PRICE EACH
100505	Detachable Gauntlet (metacarpals to wrist)			
100515	Half Sleeve (wrist to elbow)			
100516	Half Sleeve & Gauntlet (metacarpals to elbow)			
101155	Half Sleeve (elbow to axilla)			
100501	Arm Sleeve (wrist to axilla)			
100503	Arm Sleeve with Attached Shoulder Flap			
100502	Arm Sleeve & Gauntlet (metacarpals to axilla)			
100504	Arm Sleeve, Gauntlet and Shoulder Flap			
101140	Arm Stump to Axilla			
Options				
101164	Zippers (see box 19)			
101167	Lining Inside Elbow			
101168	Lining Full Elbow			
101178	Lining Variation			
100027	Pocket			
101172	Adjustable Shoulder Flap (see box 20)			
101176	Contracture Seam			
1101118	1" Silicone Band			
100160	2" Silicone Band			
100150	Beige			
100158	Black			

Standard length zipper is full length. If shorter zipper is desired, please indicate length from wrist.

19 ZIPPER OPTIONS

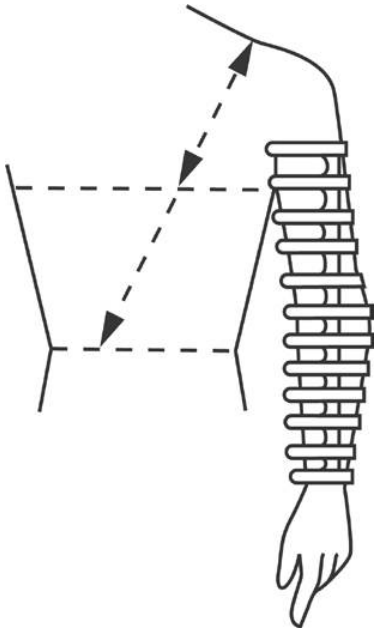
	LOCATION MARK (D) LEFT	LOCATION MARK (D) RIGHT	LENGTH IN INCHES LEFT	LENGTH IN INCHES RIGHT
LATERAL (outside) ASPECT (standard)				
MEDIAL (ulner) ASPECT(inside)				
POSTERIOR (back of hand)				
ANTERIOR (palm of hand)				

20 SHOULDER FLAP

LEFT			RIGHT		

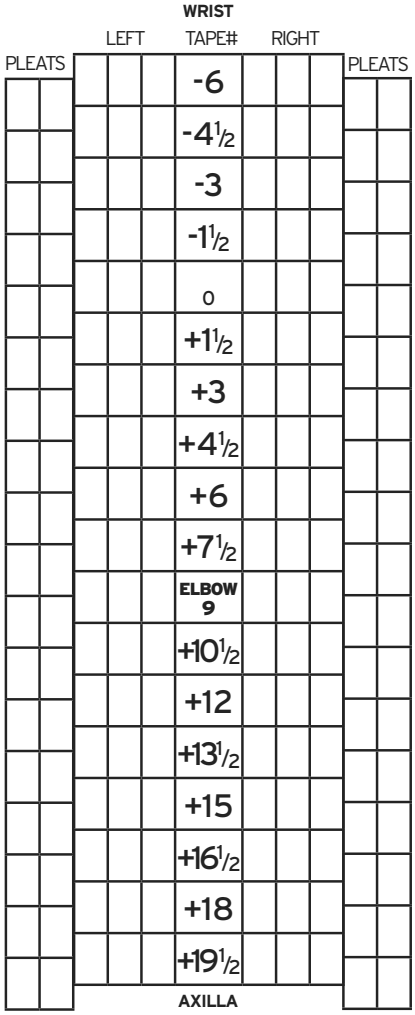
Length diagonally from top of shoulder to waist or below breast.

Give circumference for adjustable flap at waist or below breast.



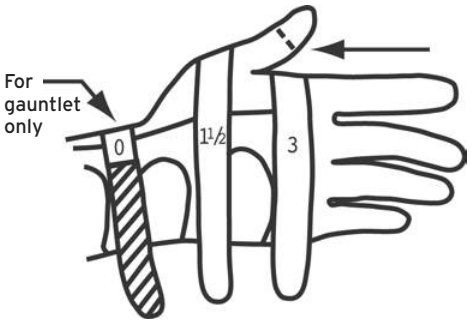
* 18 ARM CIRCUMFERENCE

***Start measuring arm from elbow to wrist then elbow to Axilla**



21 THUMB CIRCUMFERENCE

LEFT			RIGHT		



Please enter comments on page 6

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CUSTOM SEAMED – HAND

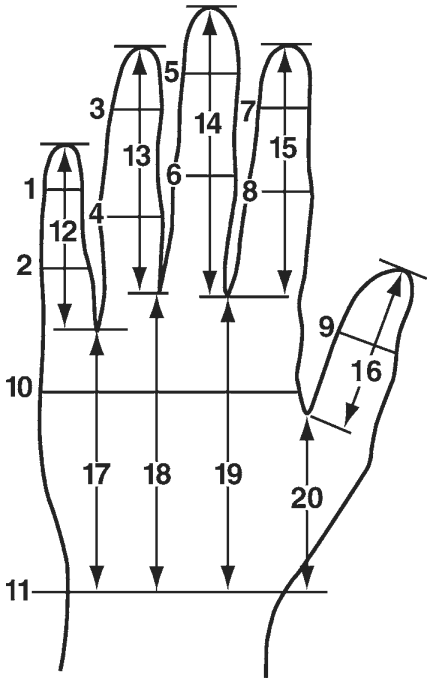
PATIENT'S NAME and/or FILE # _____

22 STYLES / OPTIONS

CAT. NO.	STYLES	QTY. LEFT	QTY. RIGHT	PRICE EACH
100532	Glove to Axilla			
100533	Glove to Axilla with Shoulder Flap			
100534	Glove to Elbow			
100535	Glove to Wrist			
100536	Interditigal Web Spacer (to be work over glove)			
100537	Mitten to Wrist			
Options				
101164	Zippers (see box 24)			
100027	Pocket			
101178	Lining Variation			
101169	Slant Inserts			
101167	Lining inside Elbow			
101168	Elbow lining (full)			
100021	Reinforced Palm or Dorsum			
100150	Beige			
100158	Black			

Length must be taken from outline drawings unless fingers are contracted.

* Hand outlines must have a 1" vertical measurement on the paper



*

23 LENGTHS (HAND OUTLINE REQUIRED)

For Open Tip, mark finished length desired		✔ IF OPEN	LEFT			RIGHT			✔ IF OPEN
Little finger to web between little finger and ring finger	12								
Ring finger to web between ring and middle fingers	13								
Middle finger to web between middle and index fingers	14								
Index finger and web between index and middle finger	15								
Thumb to thumb web	16								
Wrist to web between little and ring fingers	17								
Wrist to web between middle and ring fingers	18								
Wrist to web between index and middle fingers	19								
Wrist to thumb web	20								

24 ZIPPER OPTIONS (mark✓)

	LEFT	RIGHT
DORSAL (posterior) ASPECT (standard)		
ULNAR (little finger)		
PALMAR (anterior)		

25 CIRCUMFERENCES

		LEFT			RIGHT		
Little finger DIP	1						
Little finger PIP	2						
Ring finger DIP	3						
Ring finger PIP	4						
Middle finger DIP	5						
Middle finger PIP	6						
Index finger DIP	7						
Index finger PIP	8						
Thumb	9						
Palm	10						
Wrist	11						
1½" beyond Wrist							
3" beyond Wrist							

Please enter comments on page 6

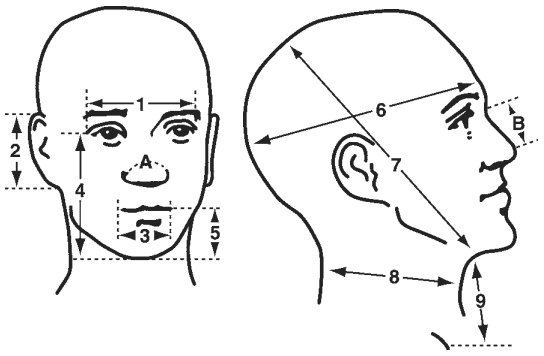
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CUSTOM SEAMED – HEAD

26 HEAD MEASUREMENTS			
Width of Eyes	1		
Length of Ear	2		
Width of Mouth	3		
Chin to Eyes	4		
Chin to Mouth	5		
Circ. above Eyebrow	6		
Around Head at Chin Angle	7		
Circ. of Neck	8		
Throat to Sternal Notch	9		
Nose Covering Across Tip	A		
Nose Covering Length	B		

PATIENT'S NAME and/or FILE # _____

27 STYLES / OPTIONS			
CAT. NO.	STYLES	QTY.	PRICE EACH
100540	Face Mask		
101158	Open Face Mask		
100550	Chin Strap		
100549	Modified Chin Stap (extends behind ear)		
Options			
101165	Nose Covering		
101166	Lip Covering		
100150	Beige		
100158	Black		



ORDER SUMMARY	
SUBTOTAL $	$0.00
Next Day Ordering Processing Fee	
SERVICE FEE	
$15 OPTIONAL OVERNIGHT SHIPPING	
(TAXABLE) SUBTOTAL	$0.00
TOTAL $	$0.00

Please enclose remittance or P.O., payable in U.S. funds or their equivalent. Sorry, NO C.O.D.'s

RUSH Service Phone, email or fax orders may receive this priority service if requested. Your order will be completed and shipped from our facility within "1" day of the day of receipt. The service fee is 30% of the total prices entire order, plus the $15.00 next day air fee. Available in the USA only.

***REQUEST FOR NEXT DAY AIR SHIPPING OPTION ONLY** (USA only) charge of $15.00

Essity Fee for reading measuring tapes - $25.00

BSN Medical Inc., an Essity company

COMMENTS

COMMENTS _____

_____

_____

_____

_____

_____

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JOBST®

Bellavar® and Custom Seamless Soft Order Form

Patient Name/ID Code or File # _____
Address _____
City/State/Zip _____
Date _____

Product / Brand	Quantity Left	Quantity Right	Sand	Black	Bronze	Caramel	Navy	Cranberry	Espresso	Sun Bronze
Seamless Soft 18-21 mmHg* (CCL 1)										
Seamless Soft 23-32 mmHg* (CCL 2)										
Seamless Soft 34-46 mmHg* (CCL 3)										
Bellavar® 23-32 mmHg* (CCL 2)										
Bellavar® 34-46 mmHg* (CCL 3)										

Basic Styles:
☐ AD ☐ AF ☐ AG ☐ AG-T ☐ AG-HT ☐ AT

Options:
☐ Closed Toe ☐ Open Toe ☐ Short Foot (closed)

Special Options:

AD
☐ No Silicone
☐ Silicone dotted band 5 cm
☐ Silicone dotted band 2.5 cm
☐ SoftFit™ (only in CCL1 & CCL2)***

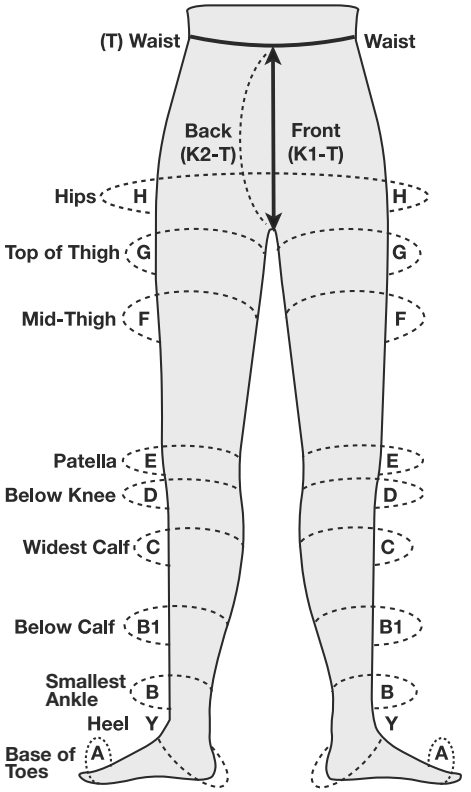
AF/AG
☐ No Silicone
☐ Silicone lace band 6 cm
☐ Silicone dotted band 5 cm
☐ Sensitive Band (Seamless Soft Only)

AT
☐ Maternity
☐ Full compression
☐ Waist band 2.5 cm**
☐ Open Pubis
☐ Fly for Men
☐ Regular Adjustable Waist band
☐ Waist band 5.0 cm**
☐ Mesh Crotch

Form 57021 must accompany this form.

Circum. (*c*)	Length (*l*)	Length (*l*)
*c*T	K2-T	*l*T
*c*H	K1-T	*l*H

Circumference (*c*)		Length (*l*): Taken from each landmark to floor	
Left	Right	Left	Right
*c*G		*l*G	
*c*F		*l*F	
*c*E		*l*E	
*c*D		*l*D	
*c*C		*l*C	
*c*B1		*l*B1	
*c*B		*l*B	
*c*Y		*l*Z (closed toe)	
*c*A		*l*A (open toe)	



Foot length open toe *l*A_____ Foot length closed toe *l*Z_____
(Not available in slant open or slant closed toe, only straight.)

Comments_____

_____

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*Design Pressure **Not available in Full Compression or Bellavar® ***Not available in Bellavar®
Take measurements on edema-free extremities only. All measurements must be recorded in cm.

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Arion and JOBST® donning aids ordering information on the back.

JOBST Elvarex® Lymphedema Garments

Foot Cap Order Form

Elvarex®, Elvarex® Plus, Elvarex® Soft Seamless

Patient Name / Essity File # _____ DOB_____ Date_____

Address _____ Gender M ☐ F ☐

City / State / Zip _____

Diagnosis _____ **PO#**

Doctor/Address _____ Original Order ☐ Reorder w Changes ☐ Exact Reorder ☐ Schema #

City / State / Zip _____

Fitter Name _____ Fitter # _____ Fitter Phone _____

Fitter Facility _____ Email _____

Ship To Acct # _____ Acct Name _____

Address _____ City _____ State_____ Zip _____

Email _____ Phone _____ Fax _____

Bill To Acct #_____ Acct Name _____

Address _____ City _____ State _____ Zip _____

Email _____ Phone _____ Fax _____

Confirmation Fax #_____

Email _____

By choosing communication via email (above), I acknowledge that Personal Health Information associated with this purchase may be transmitted from Essity in a non-encrypted manner.

Last 4 digits of credit card on file OR Exp. _____

New card - call to provide credit card #

Name on CC _____ **Billing Zip** _____

Elvarex®** ☐ Beige ☐ Black ☐ Bronze new! ☐ Cocoa ☐ Caramel new! ☐ Navy ☐ Grey ☐ Cranberry

Elvarex® Plus** ☐ Beige ☐ Cocoa ☐ Bronze new! ☐ Black ☐ Navy ☐ Caramel new! ☐ Grey ☐ Cranberry ☐ Red

Elvarex® Soft Seamless ☐ Cranberry ☐ Beige ☐ Cocoa ☐ Grey ☐ Black ☐ Navy ☐ Cherry

Qty/Class	CCL1 (18-21mmHg)	CCL2 (23-32mmHg)	CCL3† (34-46mmHg)
Left			
Right			

Small Toe Open***

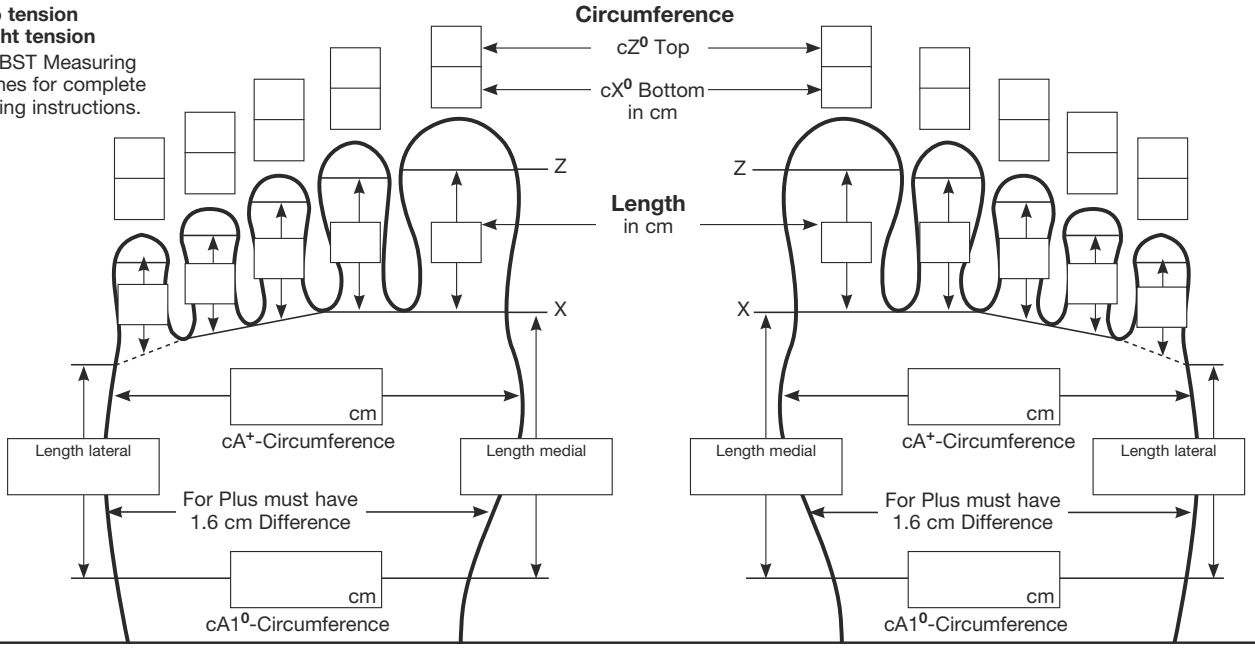
Left	☐ 0.5cm	☐ 1cm	☐ 1.5cm
Right	☐ 0.5cm	☐ 1cm	☐ 1.5cm

All 5th Toe circumferences are required for Elvarex® Plus, even if choosing open 5th toe option.

Small Toe Covered*** ☐ Left ☐ Right

0 no tension
+ light tension

See JOBST Measuring Guidelines for complete measuring instructions.



NOTE: All Elvarex® garments have an estimated arrival time of 4-5 days. Elvarex® Plus and Elvarex® Soft Seamless garments ordered in black and beige have an estimated arrival time of 4-5 business days from the date submitted. All other colours for the Elvarex Plus and Soft Seamless have an estimated arrival time of 7-10 business days from the date submitted.

* Design Pressure † Only available in Elvarex®

** **CAUTION:** This product contains natural rubber latex which may cause allergic reactions.

*** Cut-back is only available in Elvarex® and Elvarex® Plus. No cut-back in Elvarex® Soft Seamless.

For additional product order forms, please go to

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JOBST® Elvarex® Lower Extremity Order Form

Patient Name / Essity File # _____ DOB _____

Address _____ Gender M ☐ F ☐

City/State/Zip _____

Diagnosis _____ Date _____

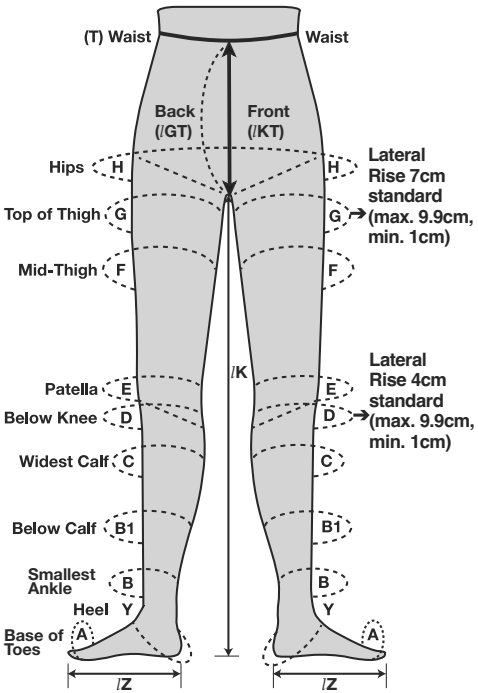
MUST INCLUDE PRESCRIPTION ORDER FORM (57021)

Quantity/Class	CCL 1 18-21 mmHg*	CCL 2 23-32 mmHg*	CCL 3 34-46 mmHg*	CCL 3F 34-46 mmHg*	CCL 4 49-70 mmHg*	CCL 4S 60-90 mmHg*
Left						
Right						
Pressure panty Elvarex® (Body Bandage)						

Circum. (*c*)	Length (*l*)	Length
*c*T^{0}	*l*GT	*l*T
*c*H^{++}	*l*KT	*l*H

Circumference (*c*)		Length (*l*): Taken from each landmark to floor	
Left	Right	Left	Right
		*l*K	
*c*G$^{++/+***}$		*l*G	
*c*F^{++}		*l*F	
*c*E^{+}		*l*E	
*c*D$^{+/0***}$		*l*D	
*c*C^{++}		*l*C	
*c*B1^{++}		*l*B1	
*c*B^{+}		*l*B	
*c*Y^{0}		*l*A (medial)	
*c*A^{+**}		*l*A (lateral)	

0 no tension
\+ light tension
++ heavy tension



Styles

- ☐ AD Knee
- ☐ AF Mid-Thigh
- ☐ AG Thigh
- ☐ AG-T (AG with chapstyle)
  - ☐ Piece
  - ☐ Pair
- ☐ AG-HT 1½ Leg Pantyhose
- ☐ AT Pantyhose
- ☐ B¹G
- ☐ BG
- ☐ FG (leg extension)
- ☐ GT Biker Shorts
- ☐ B1G-T Chap
- ☐ BT Capri
- ☐ B1T Capri

Color

- ☐ Beige
- ☐ Black
- ☐ Cocoa
- ☐ Navy
- ☐ Grey
- ☐ Cranberry
- ☐ Stone
- ☐ Aubergine
- ☐ Graphite
- ☐ Henna
- ☐ Denim
- ☐ Caramel new!
- ☐ Bronze new!

Seam Color

- ☐ Beige
- ☐ Black
- ☐ Cocoa
- ☐ Navy
- ☐ Caramel new!
- ☐ Bronze new!
- ☐ Cranberry
- ☐ Grey

Options

- ☐ T-Heel (Class 2-3 forte only)
- ☐ Profile (Not available with pocket instep)
- ☐ **SoftFit band** (Only available CCL1-3, AD only)
- ☐ **Silicone dotted band 2.5cm:**
  - ☐ Top
  - ☐ Inside
  - ☐ Inside ¾
- ☐ **Silicone dotted band 5cm:**
  - ☐ Top
  - ☐ Inside
  - ☐ Inside ¾
- ☐ **Micro dotted top band 5cm**
- ☐ **Lateral Rise AD only**
  - ☐ Standard: 4cm
  - ☐ Other:_____cm
- ☐ **Silicone Waistband 5cm**
- ☐ **Adjustable Waistband**
- ☐ **Ribbed Fleece Waistband 5cm**
- ☐ **Ribbed Comfort Waistband w/Velcro 5cm**
- ☐ **Sensitive Waistband 5cm**
- ☐ **Vertical Silicone Strips AG:**
  - ☐ Front ☐ Back
  - ☐ Both
- ☐ **Zipper B to D only:**
  - ☐ Inside (Medial)
  - ☐ Outside (Lateral)
- ☐ **Zipper E to G only:**
  - ☐ Inside (Medial)
  - ☐ Outside (Lateral)
- ☐ **Knee Comfort Zone** (Not available in CCL 1)
- ☐ **Top Comfort Zone**
- ☐ **Pocket**
  - ☐ Instep (Not available with Profile)
  - ☐ Back of Knee†
  - ☐ All four sides closed
- ☐ **Crotch options**
  - ☐ Standard
  - ☐ With Compression
  - ☐ Fly for Men
  - ☐ Open Pubis
  - ☐ Mesh

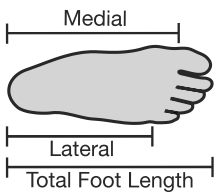
☐ **Straight Open Toe**
Lateral Length _____ cm

☐ **Straight Closed Toe**
Total Foot Length *l*Z _____ cm

☐ **Slant Open Toe**
Medial Length _____ cm
Lateral Length _____ cm

☐ **Slant Closed Toe**
Medial Length _____ cm
Lateral Length _____ cm
Total Foot Length *l*Z _____ cm

Comments: _____



CAUTION: This product contains natural rubber latex which may cause allergic reactions.

* Design Pressure
** If measuring is done in lying position, *c*A please apply 0 tension
*** If silicone band & straight ending
† Not available with Knee Comfort Zone

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JOBST Elvarex® Lymphedema Garments

Armsleeve Order Form

Elvarex®, Elvarex® Soft

Patient Name / BSN File # _____ DOB_____ Date_____

Address _____ Gender M ☐ F ☐

City/State/Zip _____

Diagnosis_____ **PO#**

Doctor/Address _____ Original Order ☐ Reorder w Changes ☐ Exact Reorder ☐

City/State/Zip_____ Schema #

Fitter Name _____ Fitter # _____ Fitter Phone _____

Fitter Facility _____ Email _____

Ship To Acct # _____ Acct Name _____

Address _____ City _____ State _____ Zip _____

Email_____ Phone _____ Fax _____

Bill To Acct #_____ Acct Name _____

Address _____ City _____ State _____ Zip _____

Email_____ Phone _____ Fax _____

Confirmation Fax #_____

Email _____

By choosing communication via email (above), I acknowledge that Personal Health Information associated with this purchase may be transmitted from BSN in a non-encrypted manner.

☐ Last 4 digits of credit card on file OR Exp. _____

☐ New card - call to provide credit card # Billing Zip _____

Name on CC _____

Elvarex®** ☐ Caramel fmr Honey ☐ Hazelnut fmr Caramel ☐ Cranberry ☐ Cherry ☐ Black ☐ Beige ☐ Bronze ☐ Grey ☐ Navy

Elvarex® Soft (N/A IN CCL2F) ☐ Beige ☐ Black ☐ Honey ☐ Cranberry ☐ Cherry ☐ Navy ☐ Grey ☐ Cocoa

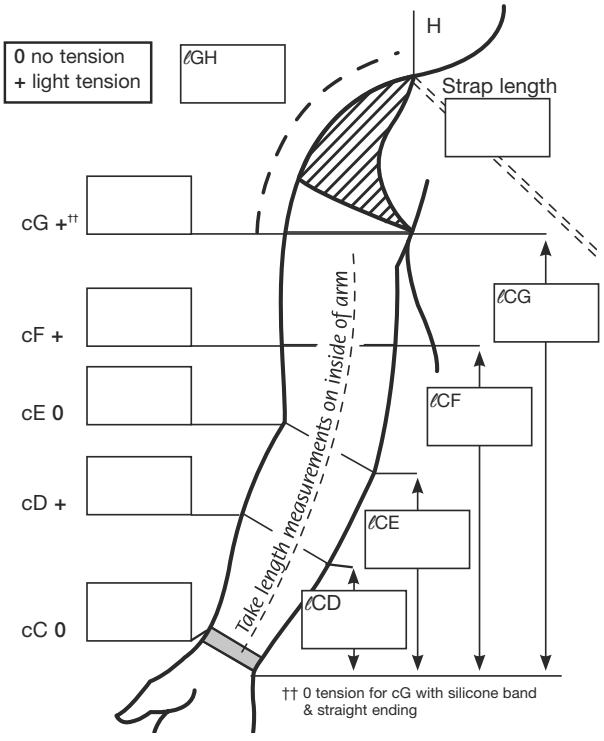
Quantity/Class	CCL1 (15-21mmHg*)	CCL2 (23-32mmHg*)	CCL2F† (23-32mmHg*)
Left			
Right			

Style (AG AH AND CH NOT AVAILABLE IN ELVAREX SOFT)

☐ CG Sleeve
☐ CH Sleeve & shoulder cap†***
☐ AG Sleeve & hand attachment†***
☐ AH Sleeve, hand attachment & shoulder cap†***

Shoulder Cap Options (CH and AH) (Elvarex only)

☐ Shoulder Strap ☐ Bra loop with Velcro _____ cm (Bra Strap width)



Elbow Options†

☐ Elbow Comfort† (CCL 2 only) (not available in Soft)
☐ Pocket Inside Elbow† (Not available with Elbow Comfort)
☐ Lining† (Pocket all sides closed)

Silicone Band	On Top	Inside	Inside ½ Elvarex only	Inside ¾ Elvarex only
2.5 cm				
5 cm				
SoftFit (C-G only)				
Micro Dot 5 cm				

Zipper†	Inside	Outside	On Top
C-E only			
E-G only			

* Design Pressure *** Not available in Elvarex Soft † Only available in Elvarex

**CAUTION: This product contains natural rubber latex which may cause allergic reactions.

NOTE: Garments ordered in black and beige have an estimated arrival time of 4-5 business days from the date submitted. All other colors have an estimated arrival time of 7-10 business days from the date submitted.

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Arion and JOBST® donning aids ordering information on the back.

JOBST Elvarex® Glove/Gauntlet Order Form

Elvarex®, Elvarex® Plus, Elvarex® Soft Seamless

Patient Name / BSN File # _____ DOB_____ Date_____

Address _____ Gender M ☐ F ☐

City/State/Zip _____

Diagnosis_____ **PO#**

Doctor/Address _____ Original Order ☐ Reorder w Changes ☐ Exact Reorder ☐

City/State/Zip _____ Schema #

Fitter Name _____ Fitter # _____ Fitter Phone _____

Fitter Facility _____ Email _____

Ship To Acct # _____ Acct Name _____

Address _____ City _____ State _____ Zip _____

Email_____ Phone _____ Fax _____

Bill To Acct #_____ Acct Name _____

Address _____ City _____ State _____ Zip _____

Email_____ Phone _____ Fax _____

Confirmation Fax #_____

Email _____

By choosing communication via email (above), I acknowledge that Personal Health Information associated with this purchase may be transmitted from BSN in a non-encrypted manner.

☐ Last 4 digits of credit card on file OR Exp. _____

☐ New card - call to provide credit card # Billing Zip _____

Name on CC _____

☐ Elvarex®** ☐ Black ☐ Caramel fmr Honey ☐ Beige ☐ Hazelnut fmr Caramel

☐ Elvarex® Plus** ☐ Cranberry ☐ Navy ☐ Cherry ☐ Bronze ☐ Grey ☐ Red

Elvarex® Soft Seamless ☐ Beige ☐ Cranberry ☐ Grey ☐ Black ☐ Cherry ☐ Cocoa ☐ Honey ☐ Navy

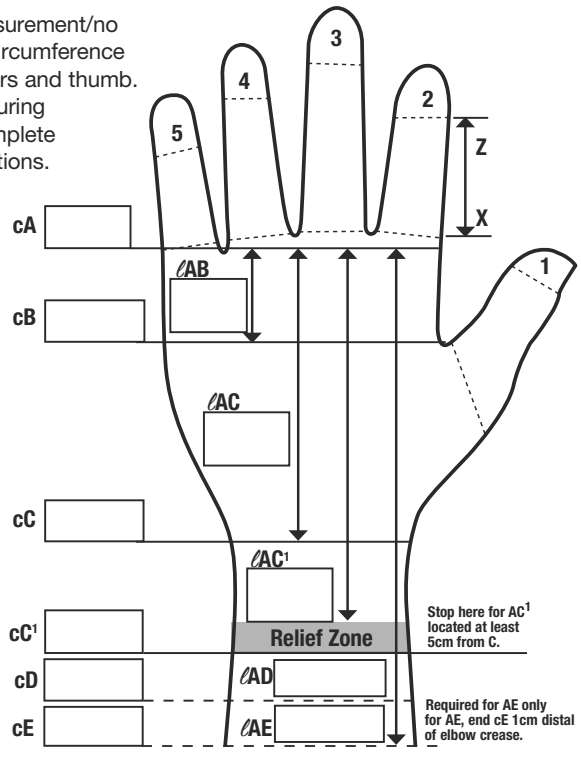
Qty/Class	CCL1 (15-21mmHg*)	CCL2 (23-32mmHg*)	CCL2F† (23-32mmHg*)
Left			
Right			

Style
☐ AC¹ Glove ☐ AC¹ Gauntlet ☐ AE Glove to Elbow ≥13 cm past wrist ☐ AE Gauntlet to Elbow ≥13 cm past wrist

Pocket† ☐ Back of hand ☐ Palm

Zipper† ☐ Back of hand ☐ Palm

Apply lay-on measurement/no tension to every circumference on the hand, fingers and thumb. See JOBST Measuring Guidelines for complete measuring instructions.



	Circ. Z	Circ. X	Length Z-X min. 1cm
Thumb 1			
Finger 2			
Finger 3			
Finger 4			
Finger 5			

* Design Pressure

****CAUTION:** This product contains natural rubber latex which may cause allergic reactions.

† Only available in Elvarex®

NOTE: Garments ordered in black and beige have an estimated arrival time of 4-5 business days from the date submitted. All others colors have an estimated arrival time of 7-10 business days from the date submited.

For additional product order forms, please go to

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JOBST Confidence®

Confidence® Armsleeve Order Form

Date:_____ Purchase Order #:_____ Patient Name: _____ DOB: _____

Fitter Name: _____ Fitter #: _____ Phone:_____

Bill To: _____ Ship To:_____

Billing Address:_____ Shipping Address:_____

☐ Last 4 digits of credit card on file OR Exp. _____

☐ New card - call to provide credit card # Billing Zip_____

Name on CC_____

Confirmation Fax # _____

Email_____

By choosing communication via email (above), I acknowledge that Personal Health Information associated with this purchase may be transmitted from Essity in a non-encrypted manner.

Quantity/Class	CCL1 (15-21mmHg*)	CCL2 (23-32 mmHg*)
Left		
Right		

Styles
- ☐ CG1
- ☐ AG1

Color
- ☐ Beige
- ☐ Black
- ☐ Caramel
- ☐ Hazelnut *NEW!*
- ☐ Cranberry *NEW!*
- ☐ Jeans Heather
- ☐ Red Heather
- ☐ Anthracite Heather

Elbow Options
- ☐ Elbow Comfort Zone

Elbow Bend Options
- ☐ Elbow 25 Degree (standard)
- ☐ Elbow 45 Degree

Silicone Band
- ☐ No Silicone
- ☐ SoftFit 2.5cm
- ☐ 2.5cm Top
- ☐ 2.5cm Inside 1/2

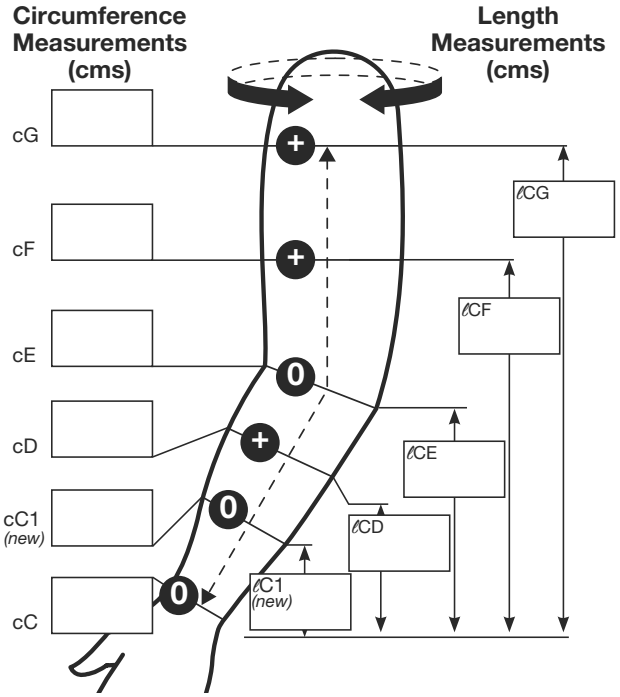
Seam Options *NEW!*
- ☐ Gold ☐ Silver ☐ Multi Color

Decorative Options
- ☐ Decorative Line (Front of garment)
- ☐ Patient Initials
  Max 2 letters (A-Z) _____

Lateral Rise is 10% of circumference at G and is not adjustable (ex: if cG is 35cm then lateral rise is 3.5cm

* Design Pressure

For additional product order forms, please go to:



Measuring Guidelines

(Only applicable for Confidence)

See Arm Diagram for applicable tension at each landmark.

Apply lay-on measurement/no tension to every circumference on the hand, fingers and thumb. See JOBST Measuring Guidelines for complete measuring instructions.

0 no tension

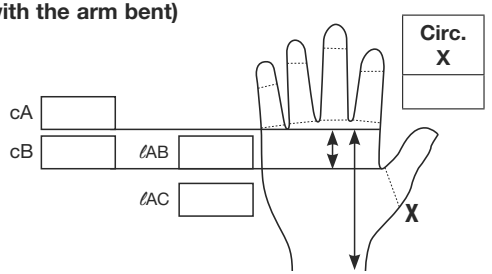
+ light tension

cG = 0 no tension with silicone band

cG = + light tension without band

ℓC1 = 5 to 7cm above cC

(ℓCG must be taken with the arm bent)



Comments

Signature: _____

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JOBST Confidence®

Confidence® Lower Extremity Order Form

Date:_____ Purchase Order #:_____ Patient Name: _____ DOB: _____

Fitter Name: _____ Fitter #: _____ Phone:_____

Bill To: _____ Ship To:_____

Billing Address:_____ Shipping Address:_____

☐ Last 4 digits of credit card on file OR Exp. _____

☐ New card - call to provide credit card # Billing Zip_____

Name on CC_____

Confirmation Fax # _____

Email_____

By choosing communication via email (above), I acknowledge that Personal Health Information associated with this purchase may be transmitted from Essity in a non-encrypted manner.

Quantity/Class	CCL1 (18-21mmHg*)	CCL2 (23-32mmHg*)	CCL3 (34-46mmHg*)
Left			
Right			

Style

☐ AD Knee ☐ AG Thigh ☐ AT Panty
☐ AB1 Sock ☐ BT Capri ☐ B1T Capri
☐ CT Capri ☐ ET Bermuda ☐ AG-HT 1 Leg Panty

Color

☐ Beige ☐ Black ☐ Caramel
☐ Hazelnut *NEW!* ☐ Cranberry *NEW!* ☐ Jeans Heather
☐ Red Heather ☐ Anthracite Heather

AD Band Options

☐ Without Silicone
☐ SoftFit Band 5cm (AD only)

AG Band Options

☐ Dotted Band 5cm with Lateral Rise

Confidence Options

☐ Lateral Rise AD/AG (10% of cD/cG)
☐ Men's style
  ☐ with fly
  ☐ without fly
☐ Adjustable Knitted Waistband Women 5cm *NEW!*
☐ Floral Waistband Women 5cm
☐ Elastic Waistband Women 5cm
☐ Adjustable Knitted Waistband Men 4cm *NEW!*
☐ Elastic Waistband Men 4cm
☐ Decorative Line (Front of garment)
☐ Patient Initials Max 2 letters (A-Z) _____
☐ Ankle Comfort Zone
☐ Knee Comfort Zone
☐ Hallux Valgus (slant toe option only)

Seam Optional *NEW!*

☐ Gold ☐ Silver ☐ Multi Color

Motivational Print Options *NEW!*

5cm waistbands only

☐ Empower Yourself ☐ Feel Good ☐ Keep Moving

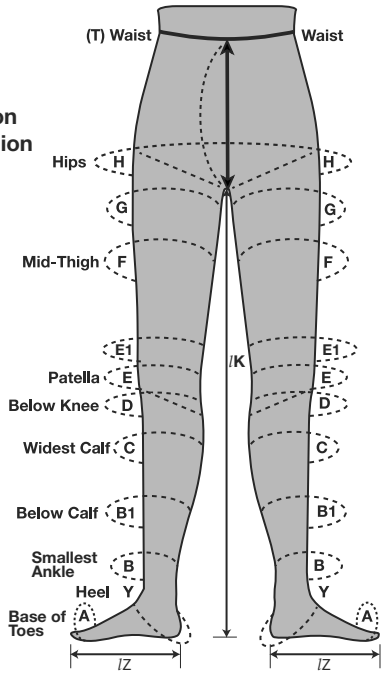
* design pressure

Circum. (c)	Length (l)	Length (l)
cT⁰	lTT	lT
cH⁰	lK3	lH

Circumference (c)		Length (l): Taken from each landmark to floor	
Left	Right	Left	Right
		lK	
cG++/+**		lG	
cF++		lF	
cE1*		lE1	
cE+		lE	
cD+/0**		lD	
cC++		lC	
cB1++		lB1	
cB+		lB	
cY⁰		AT leg lengths and CCL must be equal.	
cA+			

Measuring Guidelines

0 no tension
+ light tension
++ heavy tension

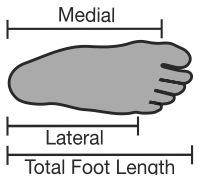


Foot Measurements for both

	Left	Right
Medial lA		
Lateral lA		
Total Foot lZ		

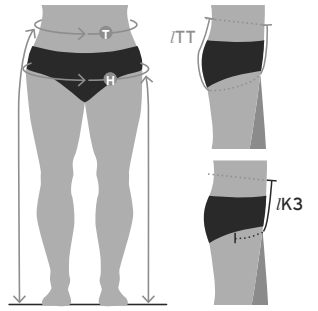
☐ Straight Open Toe ☐ Slant Open Toe
☐ Straight Closed Toe ☐ Slant Closed Toe

Chose one toe option



* cE1 for Bermuda only, measure 4cm above kneecap

** When selecting silicone band & straight ending



Signature: _____

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TO ORDER:

Relax Order Form

JOBST

Patient Name / BSN File # _____ DOB _____
Address _____ Gender M ☐ F ☐
City/State/Zip _____
Diagnosis _____
Doctor / Address _____
City/State/Zip _____

PO#

Original Order ☐ Reorder w Changes ☐
Exact Reorder ☐
Schema # _____

Fitter Name _____ Fitter # _____ Fitter Phone _____
Fitter Facility _____ Fitter email _____

Ship To Acct # _____ Acct Name _____
Address _____ City _____ State _____ Zip _____
Email* _____ Phone _____ FAX _____
*By choosing communication via email (above), I acknowledge that Personal Health Information associated with this purchase may be transmitted from BSN in a non-encrypted manner.

Bill To Acct # _____ Acct Name _____
Address _____ City _____ State _____ Zip _____
Email _____ Phone _____ FAX _____

☐ Last 4 digits of credit card on file _____ OR ☐ New card - call to provide credit card #
Name on CC _____ Exp. _____ Billing Zip Code _____

Armsleeves

Quantity/Class	CCL 1 (15-20 mmHg*)
Left	
Right	

Style
☐ CG Armsleeve
☐ AG Armsleeve w/gauntlet

Color
☐ Beige
☐ Rose

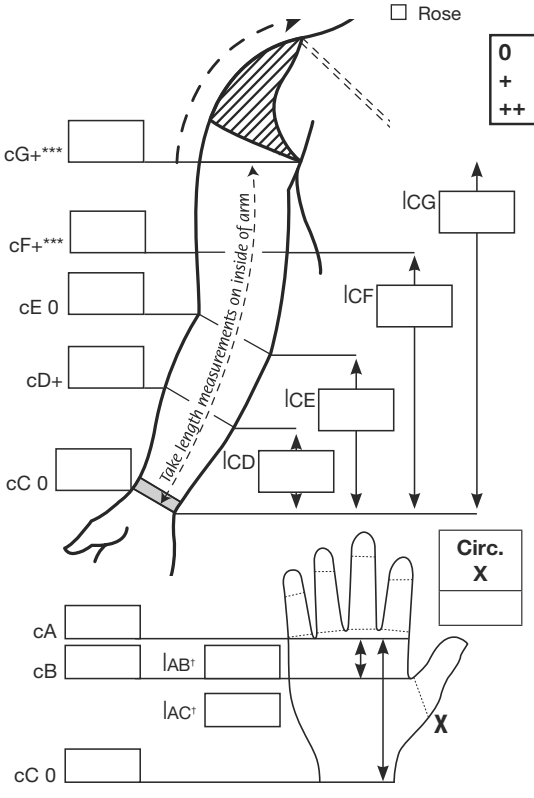
Lower Extremities

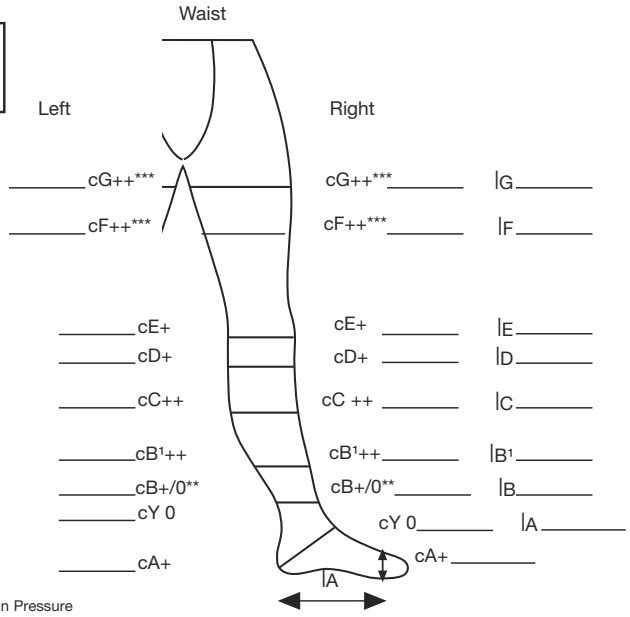
Quantity/Class	CCL 1 (15-20 mmHg*)	CCL 2 (20-30 mmHg*)
Left (AD and AG)		
Right (AD and AG)		

Style
☐ Knee High
☐ Thigh High

Color
☐ Beige
☐ Rose

0 no tension
+ light tension
++ heavy tension





* Design Pressure
** If cB is <20cm, cB should be measured with 0 tension
*** If needed, slightly more tension can be used
† Add 1 cm to IAB and IAC

Arion and JOBST® donning aids ordering information on the back.

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JOBST®
JoViPak

Arm Sleeves Custom

Patient Name:_____

PAYMENT INFORMATION

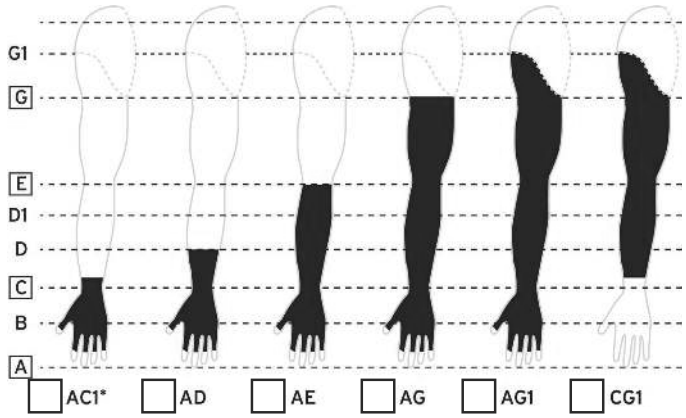
Account # (Required)	☐ Bill to Account		Date
☐ Charge Credit Card	☐☐ Card Exp. Date		PO #
Card #			Fax Confirmation #
Name on Card			Email Confirmation

BILLING ADDRESS		SHIPPING ADDRESS ☐ Same as Billing Address	
Business Name		Name	
Attention		Attention	
Address		Address	
City	State	City	State
Phone	Zip	Phone	Zip

ORDER SPECIFICATIONS

☐ Quote ☐ Order

FREE STANDARD SHIPPING



*Can be worn with a CG1

Polartec® Power Dry® Colors			
	QTY		QTY
☐ Black		☐ Buff	
☐ Pink		☐ Plum	
☐ Royal Blue			

Organic Cotton Colors			
	QTY		QTY
☐ Black		☐ Ivory	

JoViJacket			
	QTY		QTY
☐ Black		☐ White	

(JoViJackets are required to be worn with your JoVi foam garment to ensure maximum fit and effectiveness.)

Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

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JOBST JoViPak

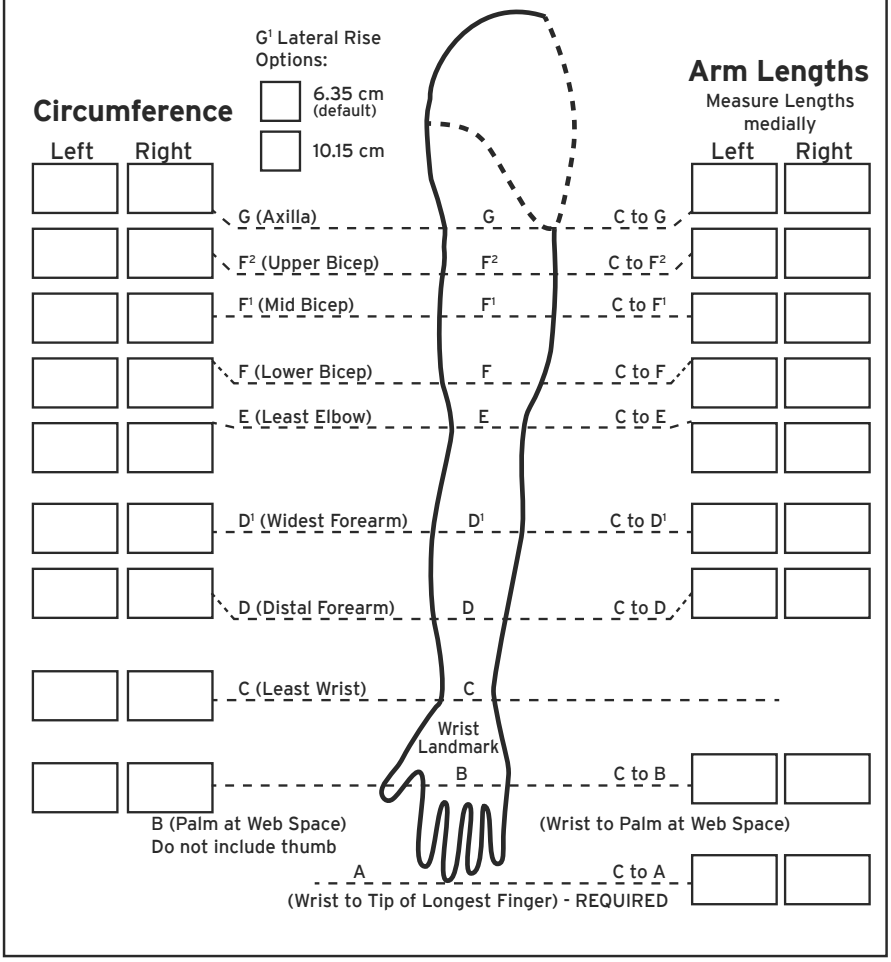
Arm Sleeves Custom

Patient Name:_____ Previous Patient? ☐ Yes Gender: ☐ F ☐ M

Height*:_____ Weight*:_____ Birthdate: _____

*Height and weight are required.

Measure extended arm in relaxed position, palm up
Please record all measurements in centimeters
All measurements are required.



Additional Charge Options

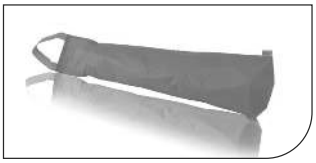
- ☐ Donning Loops
- ☐ Stitched Finger Glove
- ☐ Dorsum Pad (sewn in; provides additional pressure on dorsum)
- ☐ Palm Pad (sewn in; equalizes pressure in palm area)
- ☐ 2 Piece Arm Sleeve (AG1 or AG - separate hand; JoViJacket will match garment)
- ☐ Zipper - dorsum to forearm
- ☐ Zipper - elbow to axilla
- ☐ Zipper - wrist to elbow
- ☐ Dycem® - donning aid
- ☐ Arion Easy-Slide - donning aid (for garments without a Stitched Finger Glove)
- ☐ Prepaid Reduction

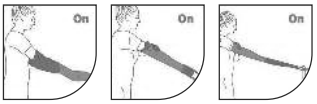
No Charge Options

- ☐ Slimline (more channels and less foam than standard channelling)
- ☐ Cover to middle of fingers
- ☐ Cover to base of fingers
- ☐ Cover fingers completely
- ☐ 2 Blend Foam (Low ILD)

Channeling:
- ☐ towards axilla region
- ☐ bypassing axilla region (default)

Dycem® is a registered trademark of Dycem Ltd.





Arion Easy-Slide Arm On

- The user-friendly application aid makes putting on compression arm sleeves quick and easy
- A straightforward donning method in combination with the application aid

Size	Circumference of widest part of the arm	BNR	UOM / Box	Order Qty.
Medium	14.5"–15.1" (37–38.5cm)	7966102	1	
Large	15.3"–16.1" (39–41cm)	7510001	1	

Comments:

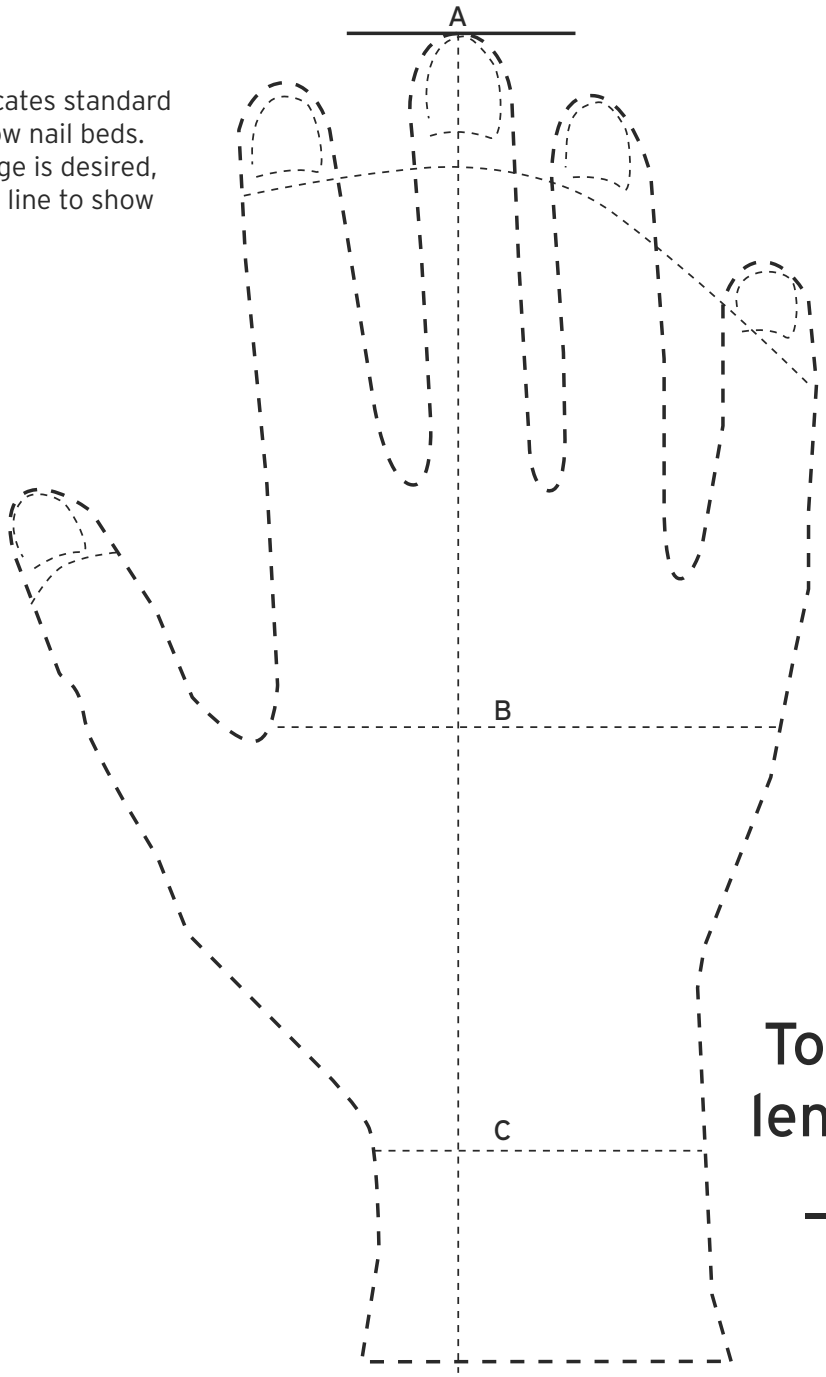
Fitter/Therapist Name: _____ Phone: _____ Email: _____

JOBST®
JoViPak

Custom Hand Tracing
Right Hand

Place hand flat, directly over this guide, palm down, with wrist flexion crease over the C landmark. Use a black pen to trace around the hand and each finger.

The dotted line indicates standard hand coverage. Below nail beds. If a different coverage is desired, sketch a new dotted line to show that coverage.



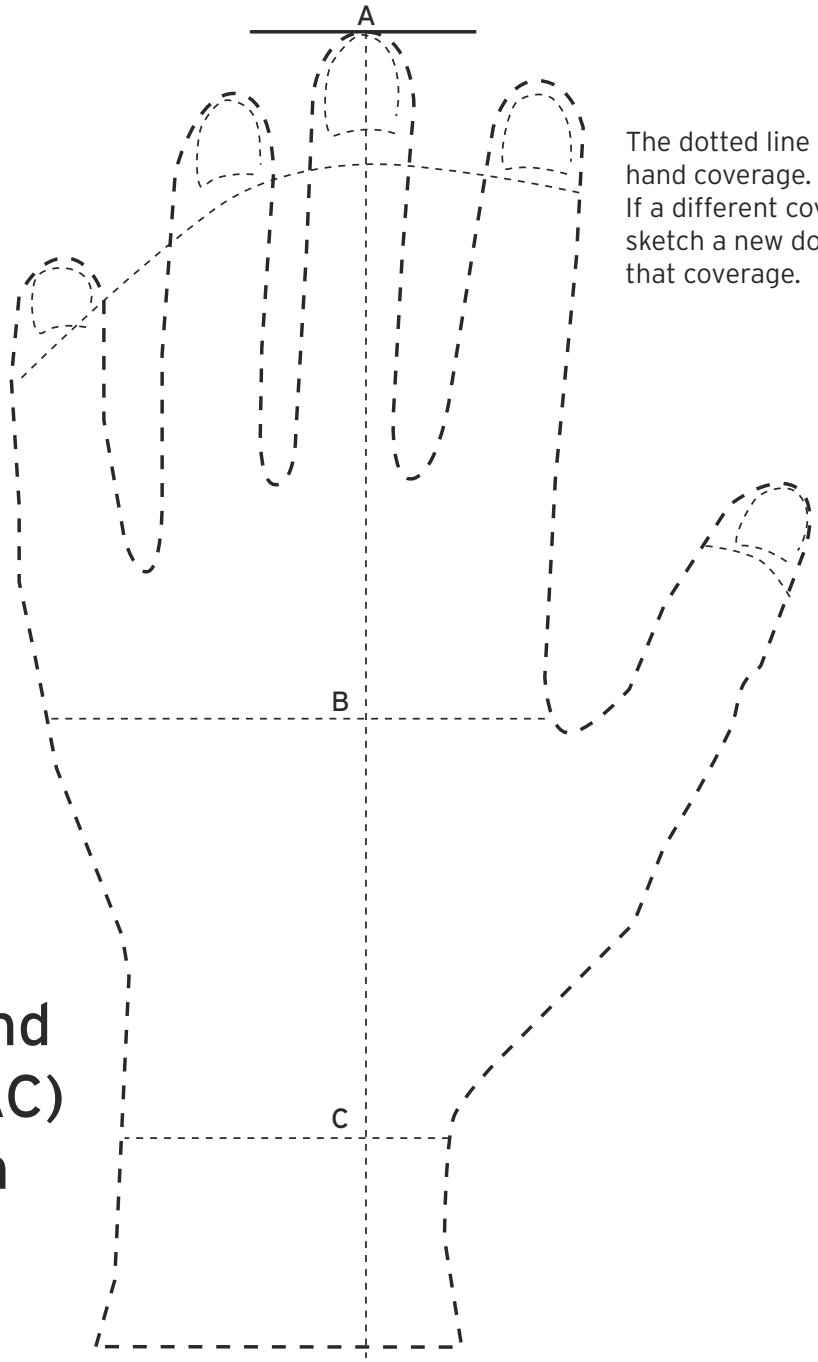
Total hand length (AC) ____cm

Patient Name or Reference # _____

JOBST®
JoViPak

Custom Hand Tracing
Left Hand

Place hand flat, directly over this guide, palm down, with wrist flexion crease over the C landmark. Use a black pen to trace around the hand and each finger.



The dotted line indicates standard hand coverage. Below nail beds. If a different coverage is desired, sketch a new dotted line to show that coverage.

Total hand length (AC) ____cm

Patient Name or Reference # _____

JOBST®
JoViPak

Boxers
Custom

Patient Name:_____

PAYMENT INFORMATION			
Account # (Required)	☐ Bill to Account		Date
☐ Charge Credit Card	☐☐ Card Exp. Date		PO #
Card #			Fax Confirmation #
Name on Card			Email Confirmation

BILLING ADDRESS		SHIPPING ADDRESS ☐ Same as Billing Address	
Business Name		Name	
Attention		Attention	
Address		Address	
City	State	City	State
Phone	Zip	Phone	Zip

ORDER SPECIFICATIONS

☐ Quote ☐ Order

FREE STANDARD SHIPPING



☐ Boxer F¹L



☐ Boxer Capri DK

Polartec® Power Dry® Colors			
	QTY		QTY
☐ Black		☐ Buff	
☐ Pink		☐ Plum	
☐ Royal Blue			

JoViJacket (Boxer - SUPER Powernet)			
	QTY		QTY
☐ Black		☐ Buff	

(JoViJackets are required to be worn with your JoVi foam garment to ensure maximum fit and effectiveness.)

Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

All sales are subject to JoViPak's Return, Guarantee and Warranty policies

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JOBST® JoViPak

Boxers
Custom

Patient Name:_____ Previous Patient? ☐ Yes Gender: ☐ F ☐ M

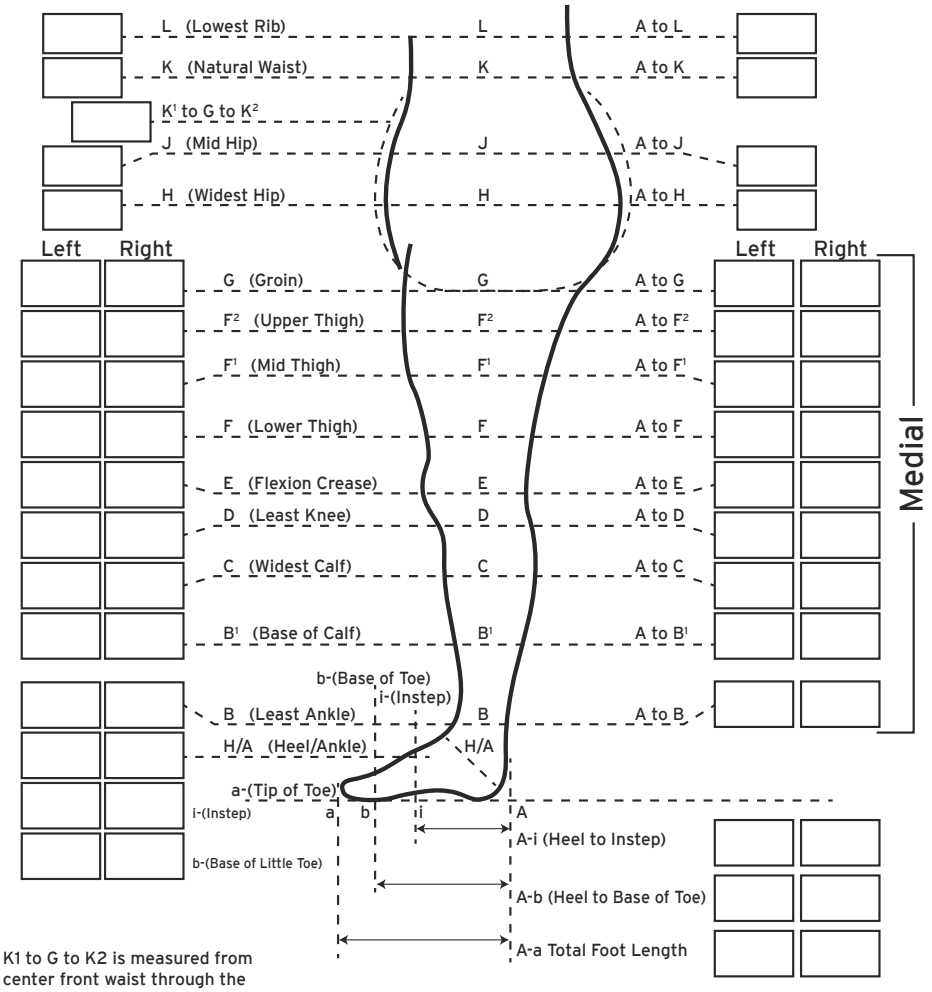
Height*:_____ Weight*:_____ Birthdate: _____

(*Height and weight are required.)

Circumference

Please record all measurements in centimeters
All measurements are required.

Leg Lengths



K1 to G to K2 is measured from center front waist through the crotch up to center back waist.

Additional Charge Options

Custom Leg AF1	☐ Left	☐ Right
Custom JoViJacket AF1	☐ Left	☐ Right
Custom Leg AD	☐ Left	☐ Right
Custom JoViJacket AD	☐ Left	☐ Right
Donning Loops options	☐ Boxer	☐ Leg(s)

☐ Dorsum Pad *(sewn in)*

Malleolus Pad *(sewn in)*
☐ Medial ☐ Lateral

☐ Zipper - ankle to knee

☐ Dycem® - donning aid

☐ Arion Easy-Slide - donning aid

Prepaid Reduction
☐ Boxer ☐ Boxer Capri
☐ AF1 Leg(s) ☐ AD Leg(s)

No Charge Options

☐ Standard: end with top of toes uncovered, cover bottom of toes

☐ Cover to tips of toes, top and bottom *(with separate AD or AF1)*

☐ End garment at base of toes, top and bottom

☐ 2 Blend Foam *(Low ILD)*

Channeling:
☐ towards inguinal region
☐ circumventing inguinal region (default)

• If ordering additional leg garments, please include foot tracings.

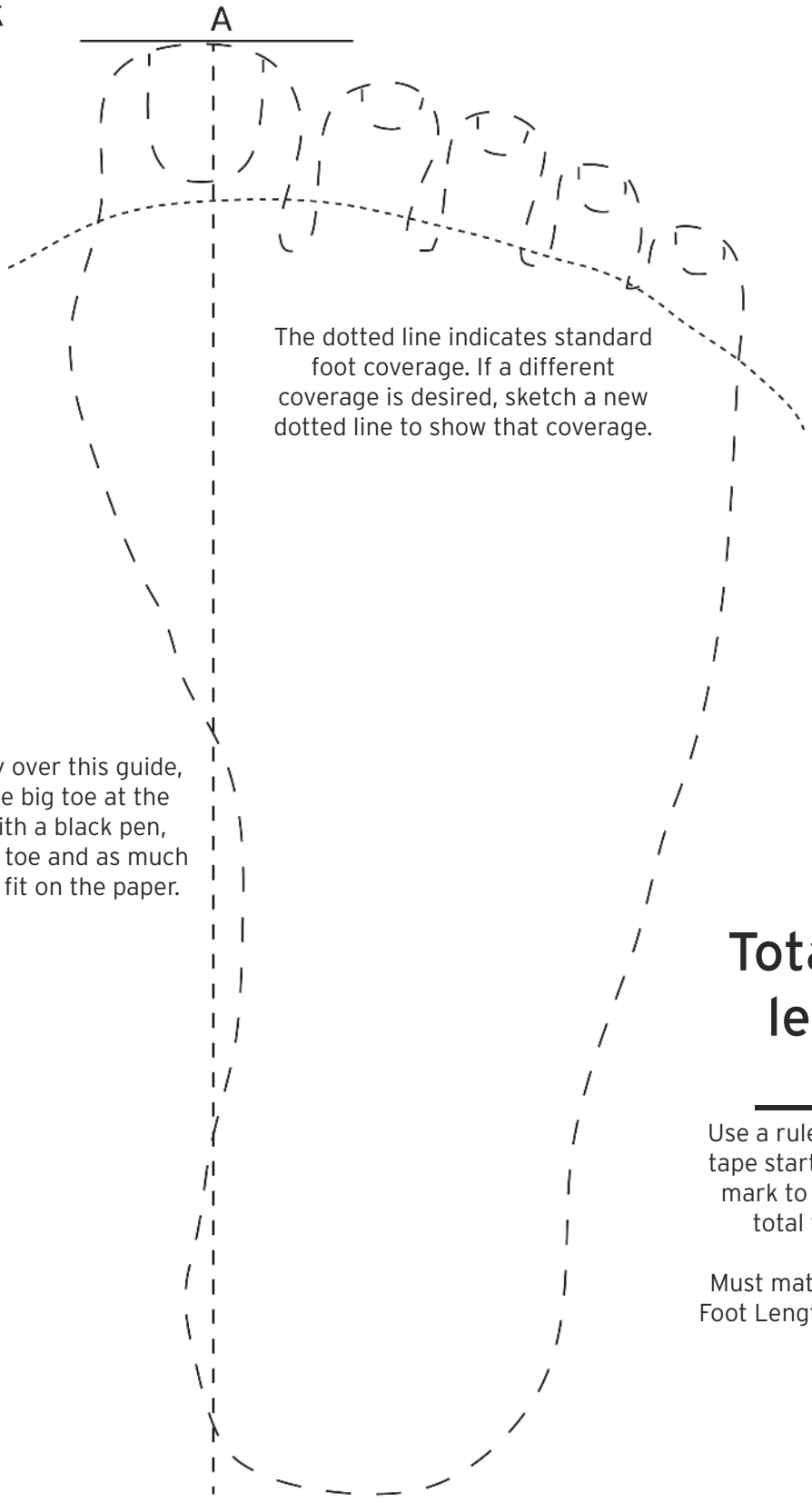
Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

All sales are subject to JoViPak's Return, Guarantee and Warranty policies

JOBST®
JoViPak

CUSTOM FOOT TRACING
RIGHT FOOT



The dotted line indicates standard foot coverage. If a different coverage is desired, sketch a new dotted line to show that coverage.

Place foot directly over this guide, with the tip of the big toe at the "A" landmark. With a black pen, trace around each toe and as much of the foot as will fit on the paper.

Total foot length ____cm

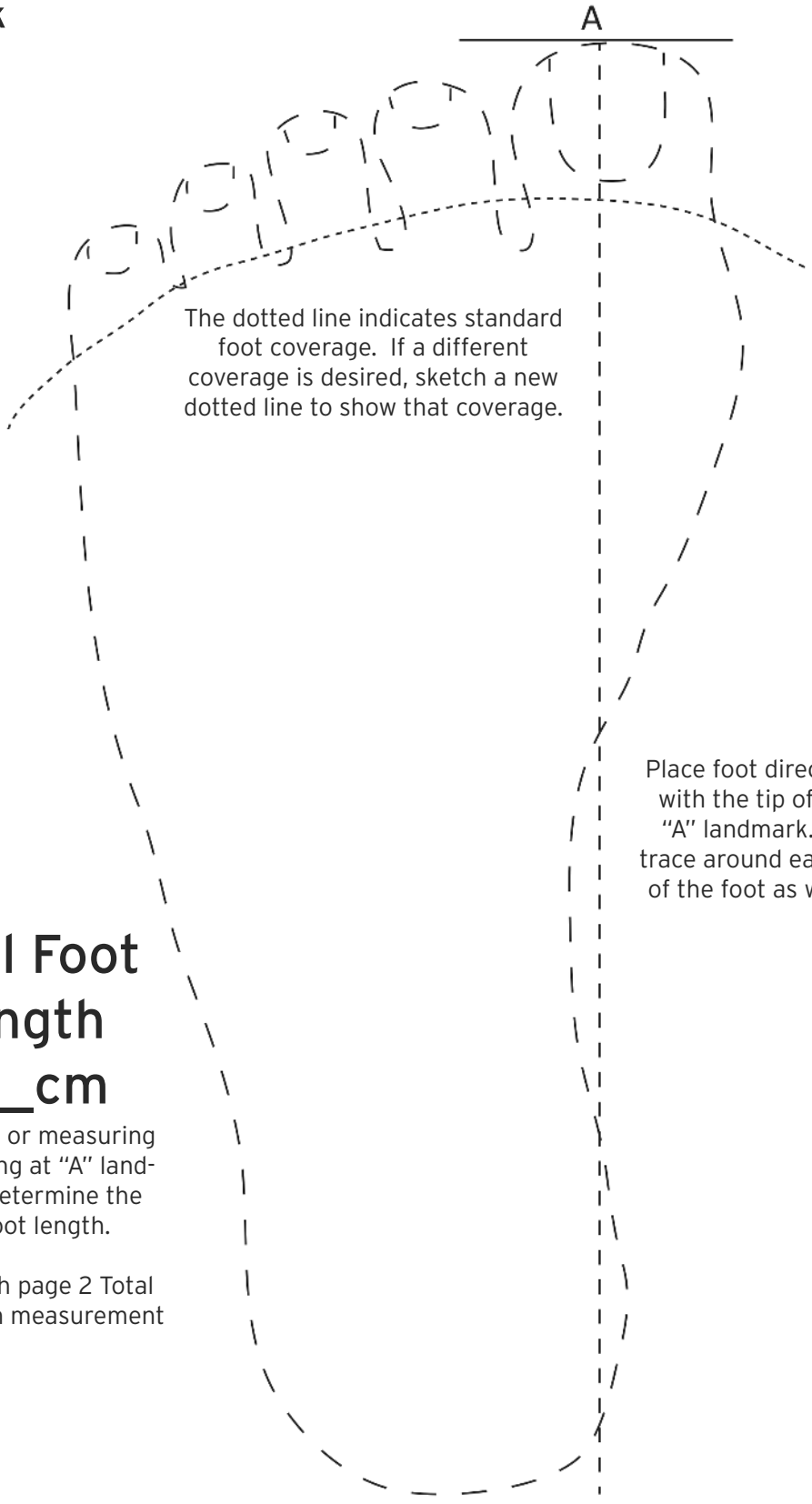
Use a ruler or measuring tape starting at "A" landmark to determine the total foot length.

Must match page 2 Total Foot Length measurement

Patient Name or Reference #:_____

JOBST JoViPak

CUSTOM FOOT TRACING
LEFT FOOT



The dotted line indicates standard foot coverage. If a different coverage is desired, sketch a new dotted line to show that coverage.

Place foot directly over this guide, with the tip of the big toe at the "A" landmark. With a black pen, trace around each toe and as much of the foot as will fit on the paper.

Total Foot Length ____cm

Use a ruler or measuring tape starting at "A" landmark to determine the total foot length.

Must match page 2 Total Foot Length measurement

Patient Name or Reference #:_____

JOBST® JoViPak

Boxers with Pannus
Custom

Patient Name:_____

PAYMENT INFORMATION			
Account # (Required)	☐ Bill to Account		Date
☐ Charge Credit Card	☐☐ Card Exp. Date		PO #
Card #			Fax Confirmation #
Name on Card			Email Confirmation

BILLING ADDRESS		SHIPPING ADDRESS ☐ Same as Billing Address	
Business Name		Name	
Attention		Attention	
Address		Address	
City	State	City	State
Phone	Zip	Phone	Zip

ORDER SPECIFICATIONS

☐ Quote ☐ Order

FREE STANDARD SHIPPING



☐ Boxer



☐ Boxer Capri

Polartec® Power Dry® Colors			
	QTY		QTY
☐ Black		☐ Buff	
☐ Pink		☐ Plum	
☐ Royal Blue			

JoViJacket (Boxer - SUPER Powernet)			
	QTY		QTY
☐ Black		☐ Buff	

(JoViJackets are required to be worn with your JoVi foam garment to ensure maximum fit and effectiveness.)

Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

All sales are subject to JoViPak's Return, Guarantee and Warranty policies

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JOBST JoViPak

Boxers with Pannus
Custom

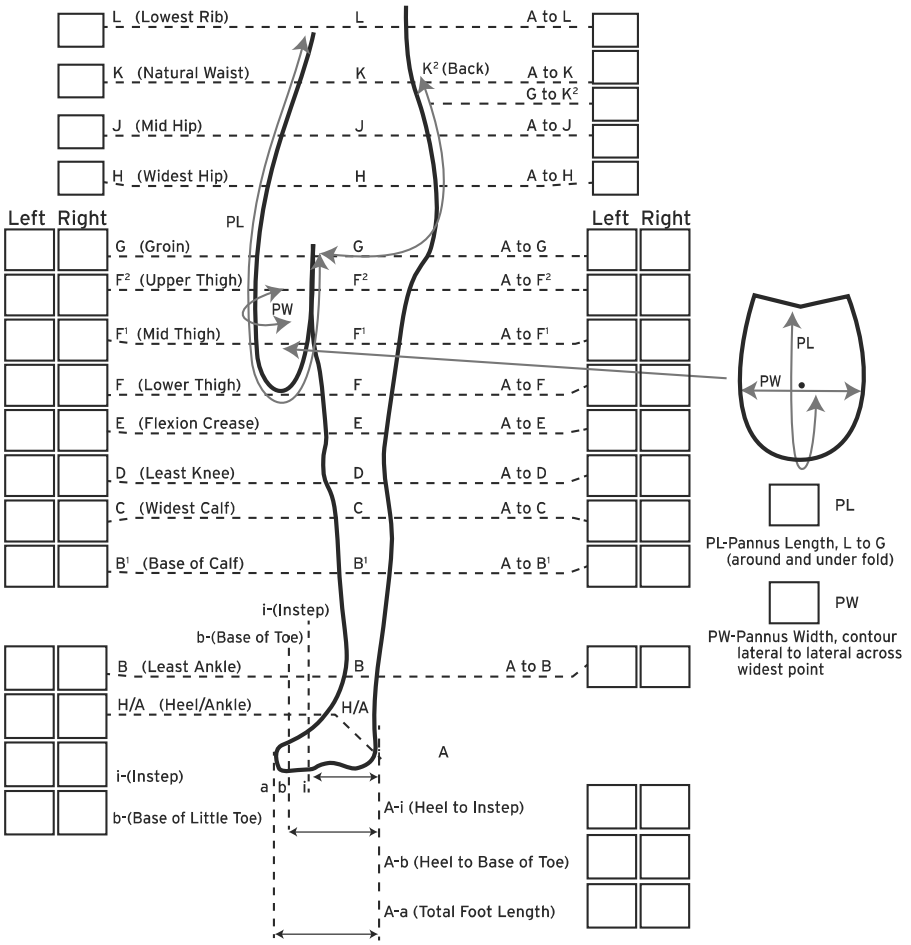
Patient Name:_____ Previous Patient? ☐ Yes Gender: ☐ F ☐ M

Height*:_____ Weight*:_____ Birthdate: _____

*Height and weight are required.

Please record all measurements in centimeters
All measurements are required.

Circumference **Length**



Additional Charge Options

- Custom Leg AF1 ☐ Left ☐ Right
- Custom JoViJacket AF1 ☐ Left ☐ Right
- Custom Leg AD ☐ Left ☐ Right
- Custom JoViJacket AD ☐ Left ☐ Right
- Donning Loop options ☐ Boxer ☐ AD ☐ AF1
- ☐ Dorsum Pad *(sewn in)*
- Malleolus Pad *(sewn in)* ☐ Medial ☐ Lateral
- Zipper - ☐ ankle to knee ☐ knee to groin ☐ 2 side zippers ☐ 1 zipper center-front, (standard)
- ☐ Dycem® - donning aid
- ☐ Arion Easy-Slide - donning aid
- Prepaid Reduction ☐ Boxer ☐ Boxer Capri ☐ AF1 Leg(s) ☐ AD Leg(s)

No Charge Options

- ☐ Standard: end with top of toes uncovered, cover bottom of toes
- ☐ Cover to tips of toes, top and bottom *(with separate AD or AF1)*
- ☐ End garment at base of toes, top and bottom
- ☐ 2 Blend Foam *(Low ILD)*
- **Channeling:** ☐ towards inguinal region ☐ circumventing inguinal region (default)

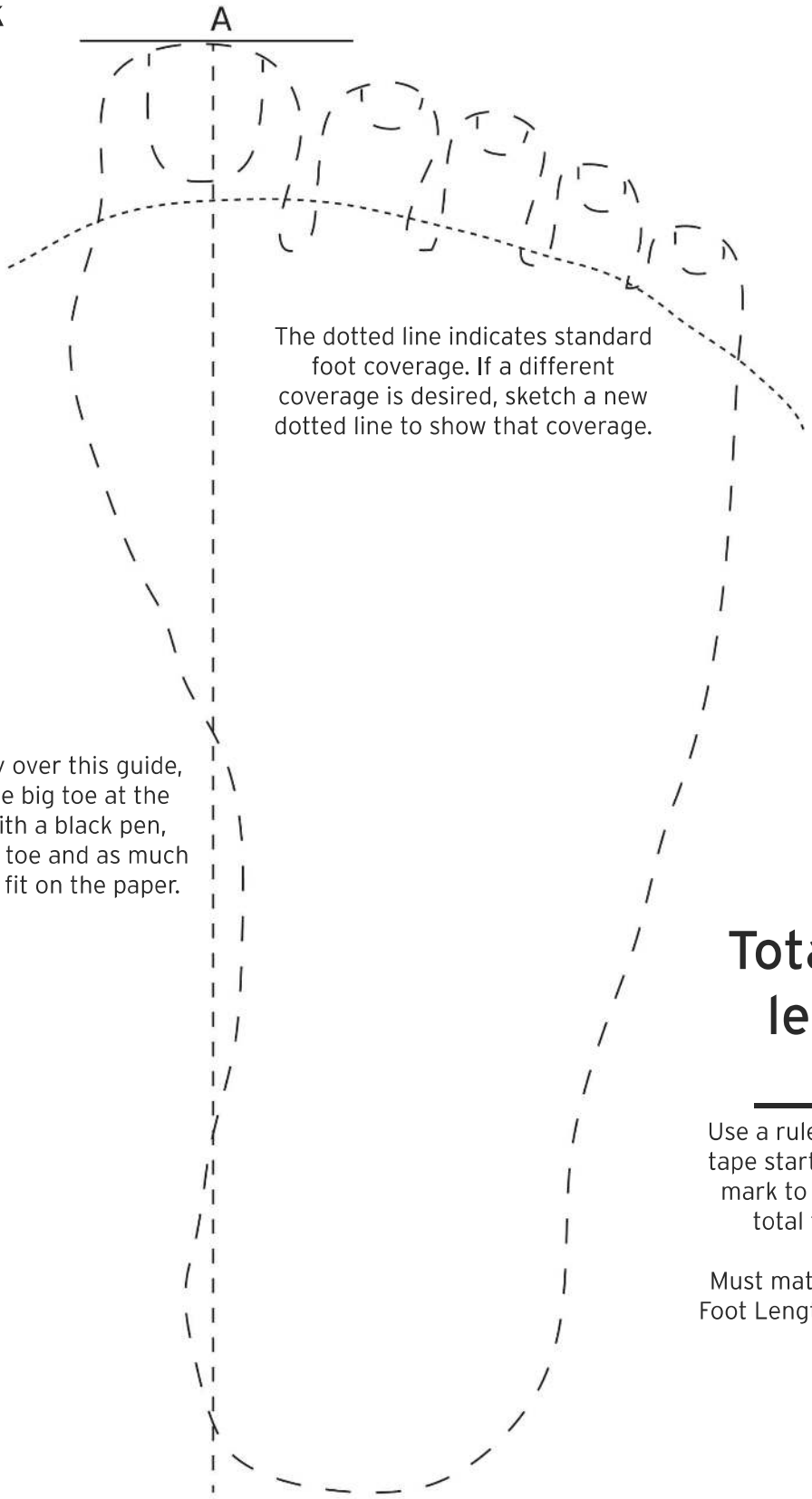
• If ordering additional leg garments, please include foot tracings.

Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

JOBST®
JoViPak

CUSTOM FOOT TRACING
RIGHT FOOT



The dotted line indicates standard foot coverage. If a different coverage is desired, sketch a new dotted line to show that coverage.

Place foot directly over this guide, with the tip of the big toe at the "A" landmark. With a black pen, trace around each toe and as much of the foot as will fit on the paper.

Total foot length

____cm

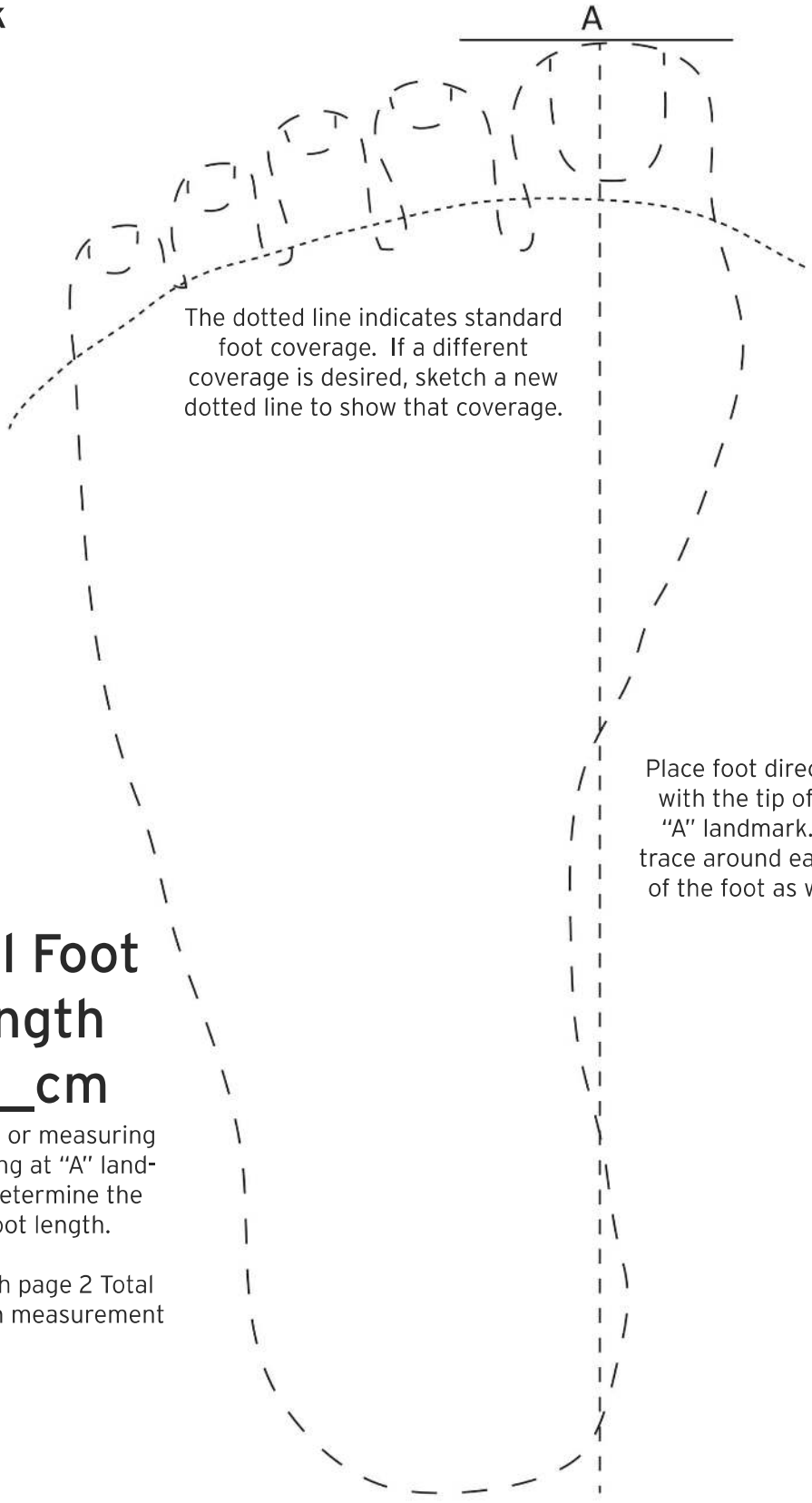
Use a ruler or measuring tape starting at "A" landmark to determine the total foot length.

Must match page 2 Total Foot Length measurement

Patient Name or Reference #:_____

JOBST®
JoViPak

CUSTOM FOOT TRACING
LEFT FOOT



The dotted line indicates standard foot coverage. If a different coverage is desired, sketch a new dotted line to show that coverage.

Place foot directly over this guide, with the tip of the big toe at the "A" landmark. With a black pen, trace around each toe and as much of the foot as will fit on the paper.

Total Foot Length

____cm

Use a ruler or measuring tape starting at "A" landmark to determine the total foot length.

Must match page 2 Total Foot Length measurement

Patient Name or Reference #:_____

JOBST® JoViPak

Busti
Custom

Patient Name:_____

PAYMENT INFORMATION			
Account # (Required)	☐ Bill to Account		Date
☐ Charge Credit Card	☐☐ Card Exp. Date		PO #
Card #			Fax Confirmation #
Name on Card			Email Confirmation

BILLING ADDRESS		SHIPPING ADDRESS ☐ Same as Billing Address	
Business Name		Name	
Attention		Attention	
Address		Address	
City	State	City	State
Phone	Zip	Phone	Zip

ORDER SPECIFICATIONS

☐ Quote ☐ Order

FREE STANDARD SHIPPING



Custom Busti



Custom Busti (posterior)

Polartec® Power Dry® Colors			
	QTY		QTY
☐ Black		☐ Buff	
☐ Pink		☐ Plum	
☐ Royal Blue			

JoViJacket - Nylon & Spandex Powernet			
	QTY		QTY
☐ Black		☐ White	

(JoViJackets are required to be worn with your JoVi foam garment to ensure maximum fit and effectiveness.)

Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

All sales are subject to JoViPak's Return, Guarantee and Warranty policies

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JOBST JoViPak

Busti
Custom

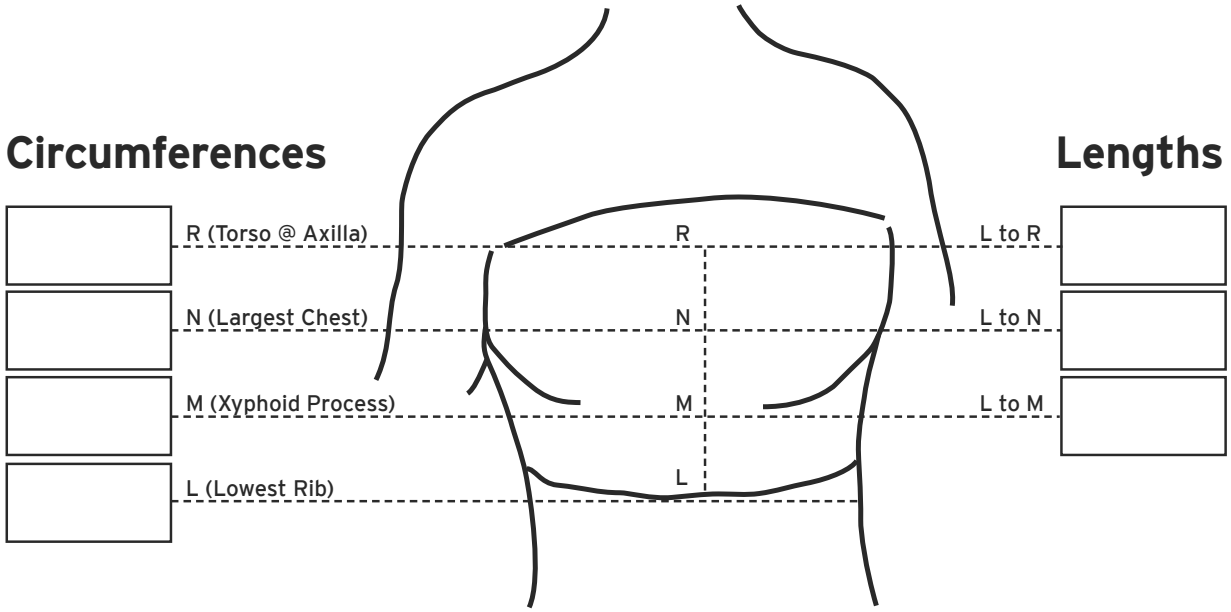
Patient Name:_____ Previous Patient? ☐ Yes ☐ No

Height*: _____ Weight*: _____ Birthdate: _____ Cup Size: _____
*Height and weight are required.

Lumpectomy ☐ Left ☐ Right **Reconstruction** ☐ Left ☐ Right

Bustis are produced with Slimline channeling (more channels and less foam than standard channeling).

Please record all measurements in centimeters
All measurements are required.



The Busti is most appropriate for lumpectomy patients. Mastectomy patients would be better served with a Custom Vest.

No Charge Options	Additional Charge Options
☐ 2 Blend Foam *(Low ILD)*	☐ Prepaid Reduction

Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

All sales are subject to JoViPak's Return, Guarantee and Warranty policies

JOBST®
JoViPak

Hip Huggers Custom

Patient Name:_____

PAYMENT INFORMATION			
Account # (Required)	☐ Bill to Account		Date
☐ Charge Credit Card	☐☐ Card Exp. Date		PO #
Card #			Fax Confirmation #
Name on Card			Email Confirmation

BILLING ADDRESS		SHIPPING ADDRESS ☐ Same as Billing Address	
Business Name		Name	
Attention		Attention	
Address		Address	
City	State	City	State
Phone	Zip	Phone	Zip

ORDER SPECIFICATIONS

☐ Quote ☐ Order

FREE STANDARD SHIPPING



☐
Hip Hugger (DK)



☐
Hip Hugger
Full Leg (AK)

Organic Cotton Colors			
	QTY		QTY
☐ Black		☐ Ivory	

JoViJacket			
	QTY		QTY
☐ Black		☐ White	

(JoViJackets are required to be worn with your JoVi foam garment to ensure maximum fit and effectiveness.)

Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

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JOBST®
JoViPak

Hip Huggers Custom

Patient Name:_____ Previous Patient? ☐ Yes Gender: ☐ F ☐ M

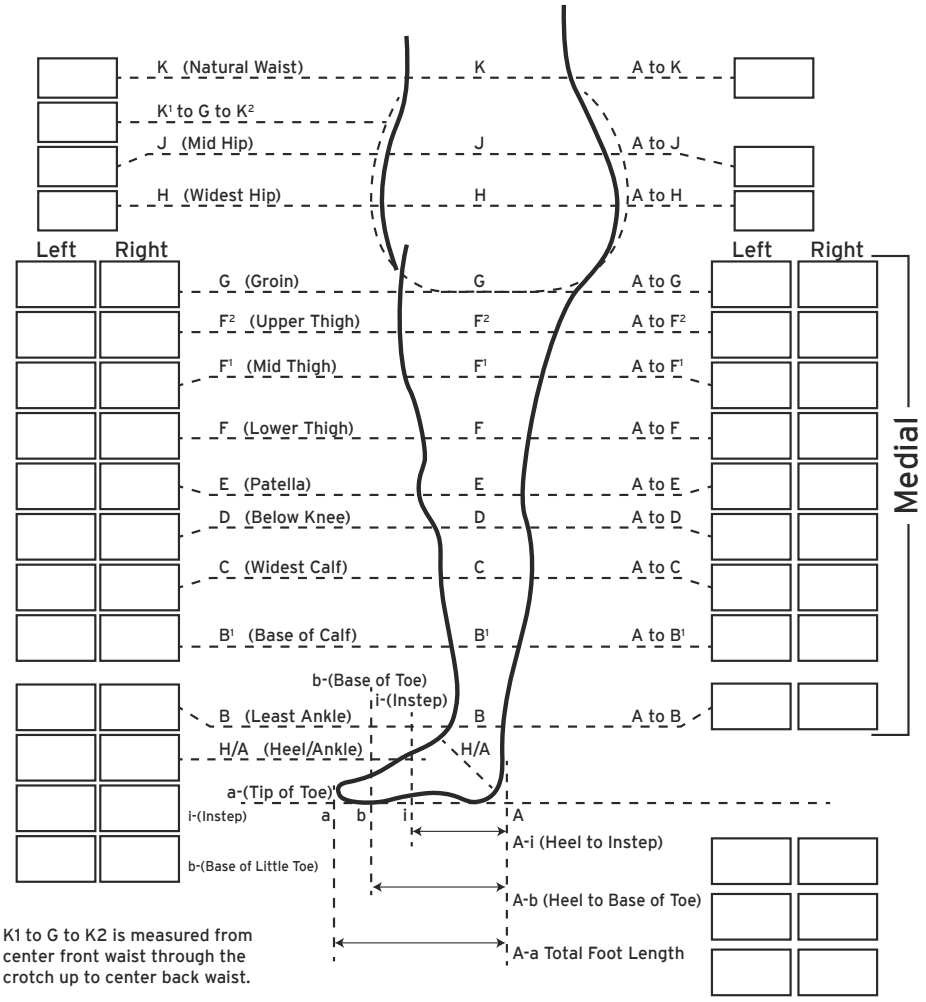
Height*:_____ Weight*:_____ Birthdate: _____

*Height and weight are required.

Circumference

Please record all measurements in centimeters
All measurements are required.

Leg Lengths



K1 to G to K2 is measured from center front waist through the crotch up to center back waist.

Can be paired with

Custom Lower Leg (AD)
☐ Left ☐ Right

Additional Charge Options

☐ **Donning Loops** ☐ **HH** ☐ **AD**

☐ **Dorsum Pad** (sewn in)

Malleolus Pad (sewn in)
☐ Medial ☐ Lateral

☐ **Zipper** - ankle to knee

☐ **Dycem®** - donning aid

☐ **Arion Easy-Slide** - donning aid

Prepaid Reduction Option
☐ Hip Hugger Full Leg (AK)
☐ Hip Hugger (DK)
☐ AD Leg(s)

Dycem® is a registered trademark of Dycem Ltd.

No Charge Options

☐ **Standard:** end with top of toes uncovered, cover bottom of toes

☐ **Cover to tips of toes, top and bottom** (with separate AD or Full Leg Hip Hugger)

☐ **End garment at base of toes, top and bottom**

☐ **2 Blend Foam** (Low ILD)

Channeling:
☐ towards inguinal region
☐ circumventing inguinal region (default)

• If ordering additional leg garments, please include foot tracings.

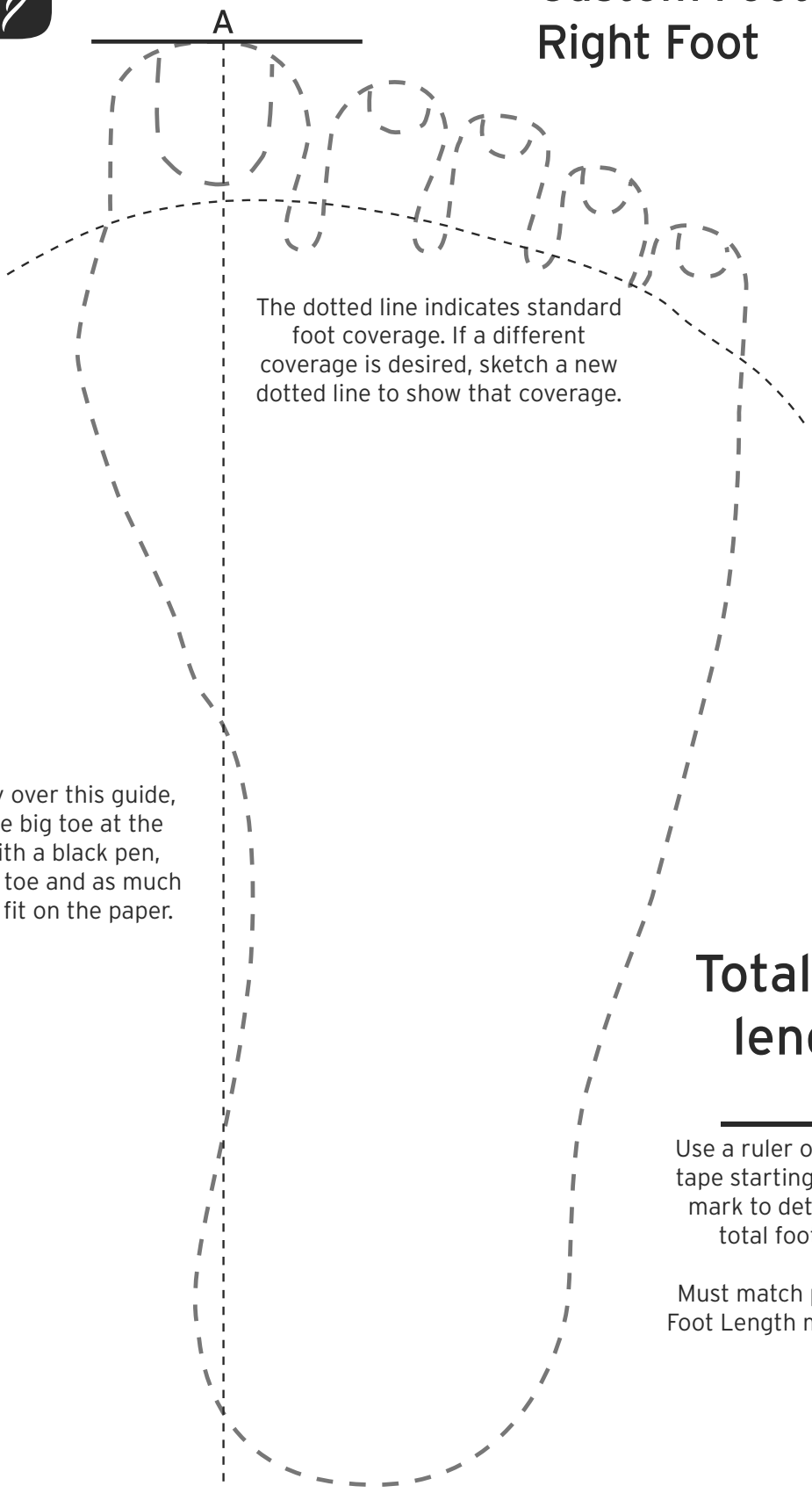
Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

All sales are subject to JoViPak's Return, Guarantee and Warranty policies

JOBST®
JoViPak

Custom Foot Tracing Right Foot



The dotted line indicates standard foot coverage. If a different coverage is desired, sketch a new dotted line to show that coverage.

Place foot directly over this guide, with the tip of the big toe at the "A" landmark. With a black pen, trace around each toe and as much of the foot as will fit on the paper.

Total foot length ____cm

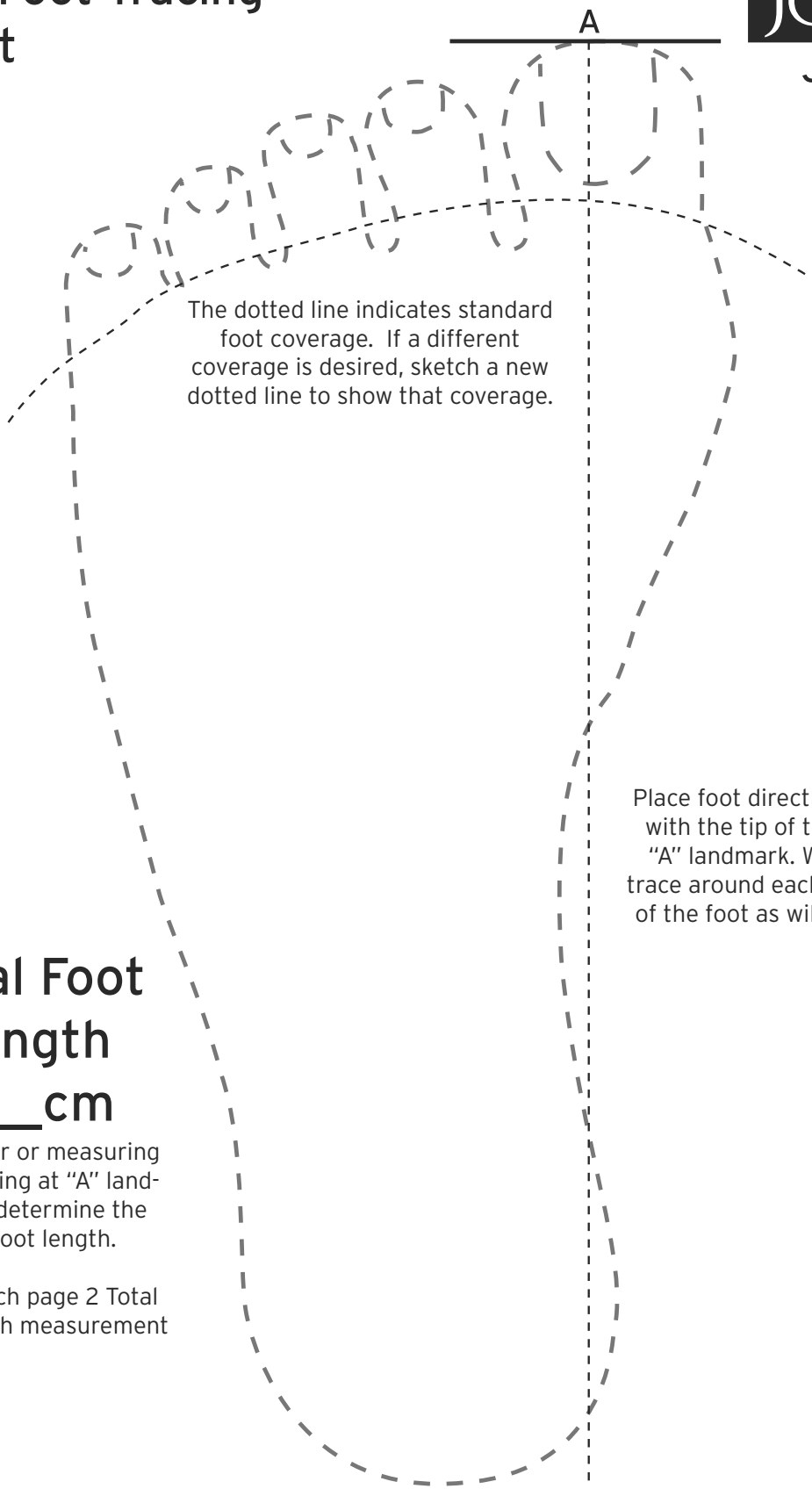
Use a ruler or measuring tape starting at "A" landmark to determine the total foot length.

Must match page 2 Total Foot Length measurement

Patient Name or Reference # _____

Custom Foot Tracing
Left Foot

JOBST JoViPak



The dotted line indicates standard foot coverage. If a different coverage is desired, sketch a new dotted line to show that coverage.

Place foot directly over this guide, with the tip of the big toe at the "A" landmark. With a black pen, trace around each toe and as much of the foot as will fit on the paper.

Total Foot Length
____cm

Use a ruler or measuring tape starting at "A" landmark to determine the total foot length.

Must match page 2 Total Foot Length measurement

Patient Name or Reference # _____

JOBST®
JoViPak

Legs Custom

Patient Name:_____

PAYMENT INFORMATION

Account # (Required)	☐ Bill to Account		Date
☐ Charge Credit Card	☐☐ Card Exp. Date		PO #
Card #			Fax Confirmation #
Name on Card			Email Confirmation

BILLING ADDRESS

Business Name	
Attention	
Address	
City	State
Phone	Zip

SHIPPING ADDRESS ☐ Same as Billing Address

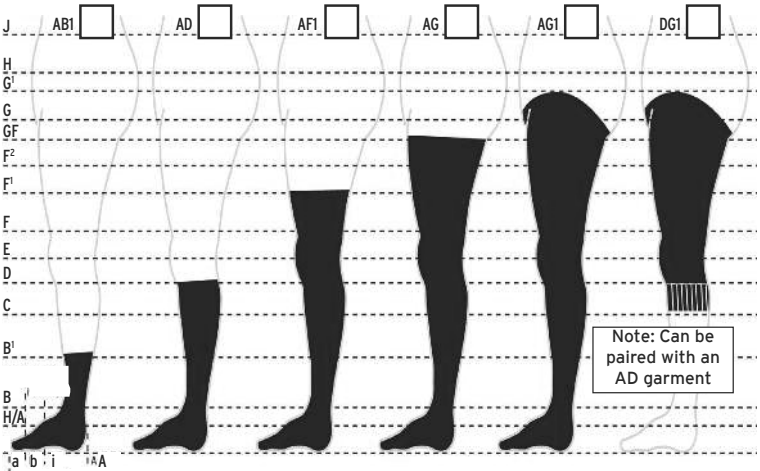
Name	
Attention	
Address	
City	State
Phone	Zip

ORDER SPECIFICATIONS

☐ Quote ☐ Order

FREE STANDARD SHIPPING

J (Mid Hip)
H (Widest Hip)
G¹ (Lateral Rise)
G (Groin)
GF (Gluteal Fold)
F² (Upper Thigh)
F¹ (Mid Thigh)
F (Lower Thigh)
E (Flexion Crease)
D (Least Knee)
C (Widest Calf)
B¹ (Base of Calf)
B (Least Ankle)
H/A (Heel/Ankle)
A (Floor or Back of Heel)



Polartec® Power Dry® Colors

	QTY		QTY
☐ Black		☐ Buff	
☐ Pink		☐ Plum	
☐ Royal Blue			

Organic Cotton Colors

	QTY		QTY
☐ Black		☐ Ivory	

SUPER Powernet Colors (InnaBoot only)

	QTY		QTY
☐ Black		☐ Buff	

JoViJacket

	QTY		QTY
☐ Black		☐ White	

(JoViJackets are required to be worn with your JoVi foam garment to ensure maximum fit and effectiveness.)

Fitter/Therapist Name: _____ Phone: _____ Email: _____

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JOBST®
JoViPak

Legs Custom

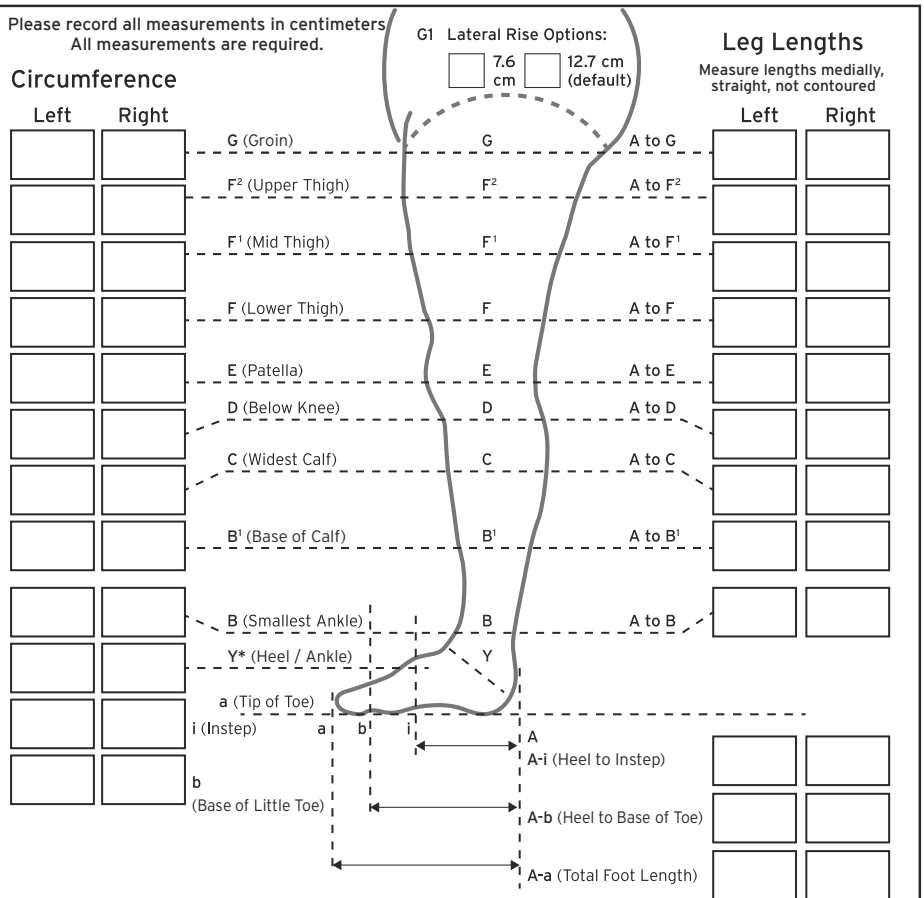
Patient Name:_____ Previous Patient? ☐ Yes Gender: ☐ F ☐ M

Height*:_____ Weight*:_____ Birthdate: _____

*Height and weight are required.

Please record all measurements in centimeters
All measurements are required.

G1 Lateral Rise Options: ☐ 7.6 cm ☐ 12.7 cm (default)



*If Y is 10 cm more than B, zipper is required.

Styles

- ☐ Standard Leg Garment (AD to AG1)
- ☐ AD - Quilted with zipper
- ☐ InnaBoot ☐ AD ☐ AG (Organic Cotton with SUPER Powernet JoViJacket)

Additional Charge Options

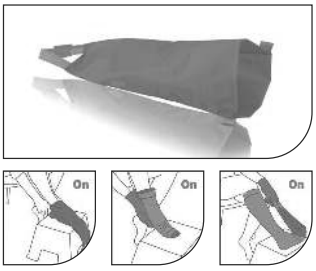
- ☐ Dorsum Pad (sewn in)
- Malleolus Pad (sewn in) ☐ Medial ☐ Lateral
- ☐ Zipper - ankle to knee
- ☐ Zipper - knee to groin
- ☐ Donning Loops
- ☐ Pull Tabs (InnaBoots only)
- ☐ Dycem® - donning aid
- ☐ Arion Easy-Slide - donning aid
- ☐ Prepaid Reduction

No Charge Options

- ☐ Standard: end with top of toes uncovered, cover bottom of toe
- ☐ Cover to tips of toes, top and bottom
- ☐ End garment at base of toes, top and bottom
- ☐ 2 Blend Foam (Low ILD)

Channeling:
- ☐ towards inguinal region
- ☐ circumventing inguinal region (default)

Dycem® is a registered trademark of Dycem Ltd.



Arion Easy-Slide On

- The user-friendly donning aid for open toe compression stockings and tights
- The lightweight, smooth material provides ease of donning/application

Size	Shoe Size	BNR	UOM / Box	Order Qty.
X-Small	≤ 2	7965803	1	
Small	2.5–5.5	7965804	1	
Medium	6–8	7965802	1	
Large	8.5–11	7965902	1	
X-Large	≥ 11.5	7966001	1	

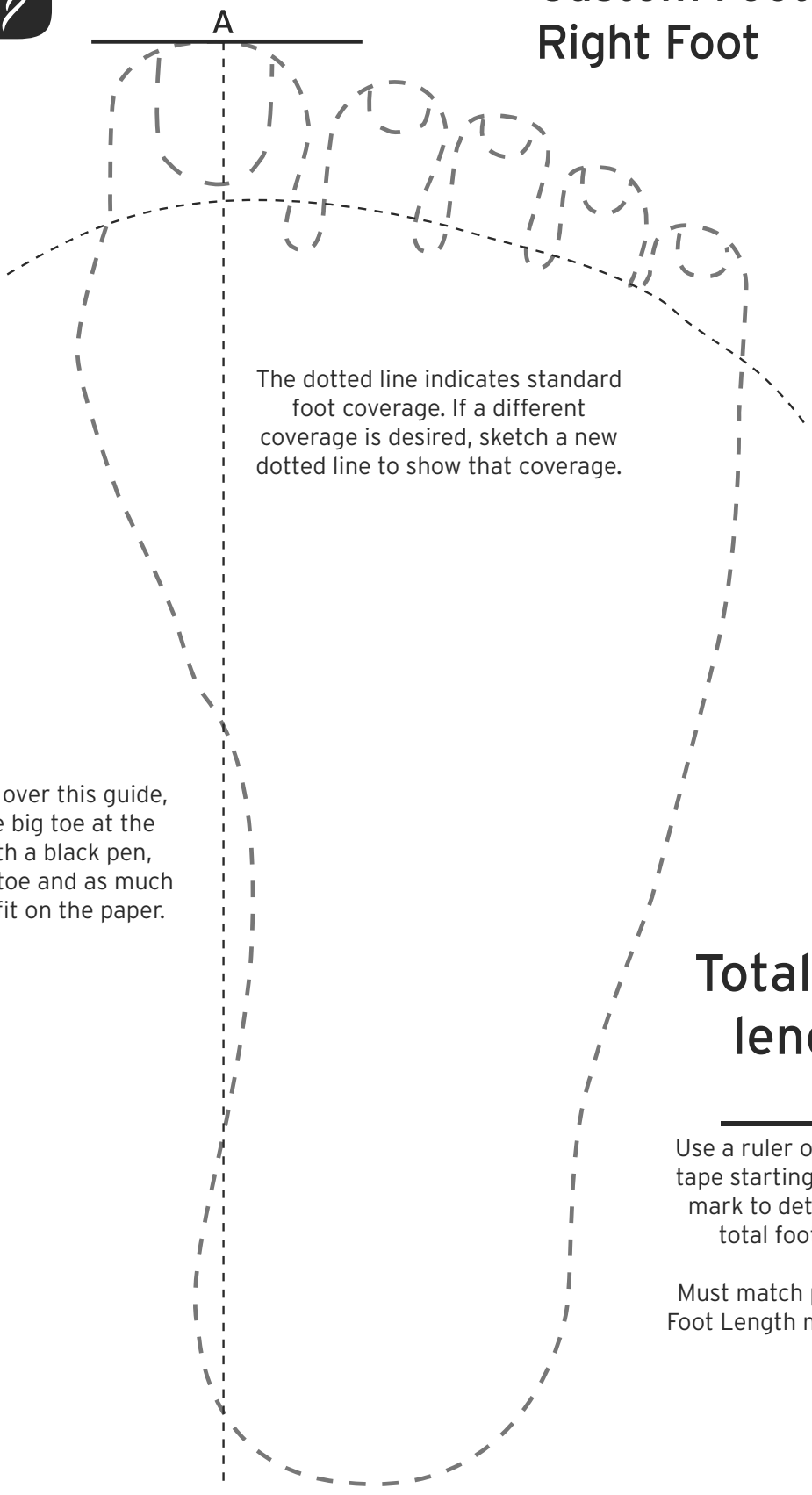
Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

All sales are subject to JoViPak's Return, Guarantee and Warranty policies

JOBST®
JoViPak

Custom Foot Tracing Right Foot



The dotted line indicates standard foot coverage. If a different coverage is desired, sketch a new dotted line to show that coverage.

Place foot directly over this guide, with the tip of the big toe at the "A" landmark. With a black pen, trace around each toe and as much of the foot as will fit on the paper.

Total foot length ____cm

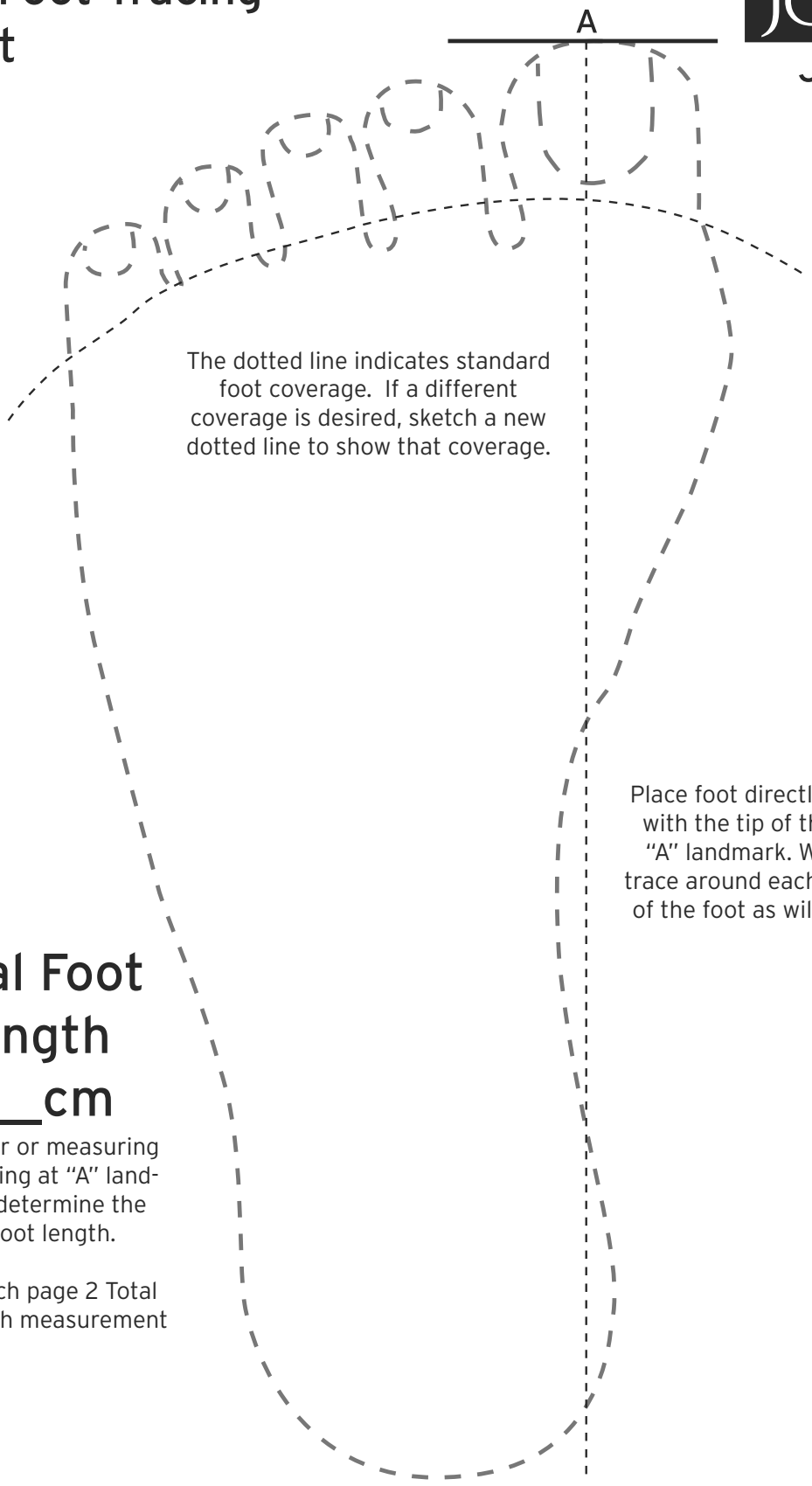
Use a ruler or measuring tape starting at "A" landmark to determine the total foot length.

Must match page 2 Total Foot Length measurement

Patient Name or Reference # _____

Custom Foot Tracing
Left Foot

JOBST JoViPak



The dotted line indicates standard foot coverage. If a different coverage is desired, sketch a new dotted line to show that coverage.

Place foot directly over this guide, with the tip of the big toe at the "A" landmark. With a black pen, trace around each toe and as much of the foot as will fit on the paper.

Total Foot Length
____cm

Use a ruler or measuring tape starting at "A" landmark to determine the total foot length.

Must match page 2 Total Foot Length measurement

Patient Name or Reference # _____

JOBST® JoViPak

Shoulder-Torso Arm Sleeves
Custom

Patient Name:_____

PAYMENT INFORMATION			
Account # (Required)	☐ Bill to Account		Date
☐ Charge Credit Card	☐☐ Card Exp. Date		PO #
Card #			Fax Confirmation #
Name on Card			Email Confirmation

BILLING ADDRESS		SHIPPING ADDRESS ☐ Same as Billing Address	
Business Name		Name	
Attention		Attention	
Address		Address	
City	State	City	State
Phone	Zip	Phone	Zip

ORDER SPECIFICATIONS

☐ Quote ☐ Order

FREE STANDARD SHIPPING



Two Piece Arm Sleeve with optional Bilateral Arms, Padded Torso, Arm Sling & Dorsum Zipper
(This option is an additional charge)



Optional Padded Torso & One Piece Arm Sleeve
(This option is an additional charge)



Unpadded torso with One Piece Arm Sleeve & recommended JoViJacket
(JoViJacket is an additional charge)

Polartec® Power Dry® Colors	QTY		QTY
☐ Black		☐ Buff	
☐ Pink		☐ Plum	
☐ Royal Blue			

JoViJacket - Nylon & Spandex Powernet	QTY		QTY
☐ Black		☐ White	

(JoViJackets are required to be worn with your JoVi foam garment to ensure maximum fit and effectiveness.)

Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

All sales are subject to JoViPak's Return, Guarantee and Warranty policies

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JOBST® JoViPak

Shoulder-Torso Arm Sleeves
Custom

Patient Name:_____ Previous Patient? ☐ Yes Gender: ☐ F ☐ M

Height*:_____ Weight*:_____ Birthdate: _____

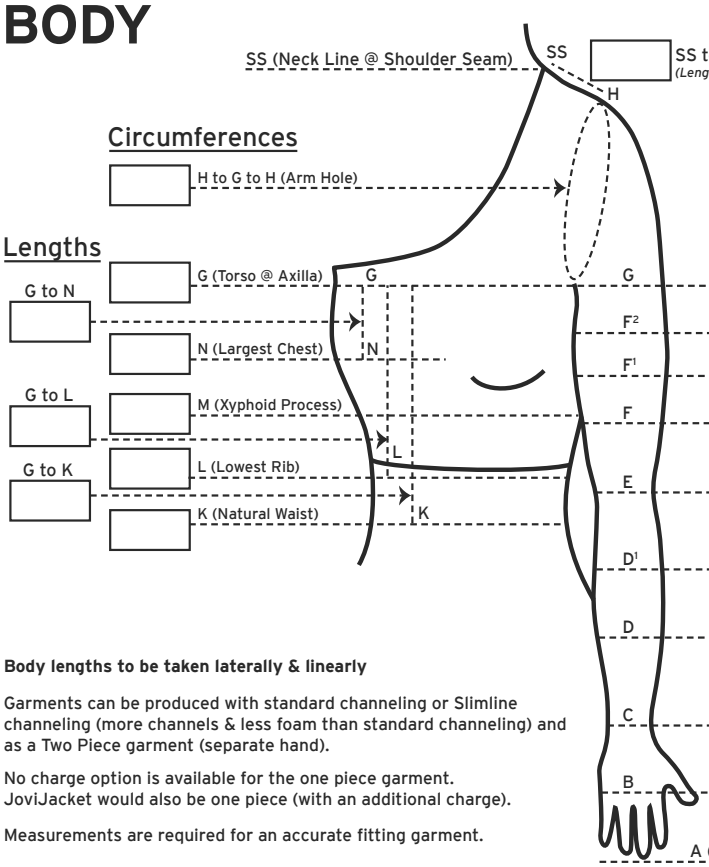
*Height and weight are required.

Must select one: **Mastectomy** ☐ Left ☐ Right **Reconstruction** ☐ Left ☐ Right **Lumpectomy** ☐ Left ☐ Right

Directions: Follow the dotted lines for measurement guidelines.

Please record all measurements in centimeters
All measurements are required

BODY



SS to H (REQUIRED)
(Length: Neck Line to Tip of Acromiom Process)

Body lengths to be taken laterally & linearly

Garments can be produced with standard channeling or Slimline channeling (more channels & less foam than standard channeling) and as a Two Piece garment (separate hand).

No charge option is available for the one piece garment. JoviJacket would also be one piece (with an additional charge).

Measurements are required for an accurate fitting garment.

ARM

Circumferences			Lengths (Measured medially)	
	Left	Right		
G			G (Axilla)	C to G
F²			F² (Upper Bicep)	C to F²
F¹			F¹ (Mid Bicep)	C to F¹
F			F (Widest Bicep)	C to F
E			E (Least Elbow)	C to E
D¹			D¹ (Widest Forearm)	C to D¹
D			D (Distal Forearm)	C to D
C			C (Least Wrist)	
B			B (Palm @ Web Space) *(Do not include thumb)*	C to B
			A (Tip of Longest Finger) *(Required)*	C to A

No Charge Options

☐ 1 piece Arm Sleeve, glove attached (JoViJacket will also be One Piece)	☐ 2 Blend Foam (Low ILD)

Additional Charge Options

Torso Padding (must select one): ☐ Horizontal Channels ☐ Vertical Channels ☐ No padding (no charge)		Padded Insert (equalizes pressure over mastectomy site) Color: ☐ Black ☐ Buff Size: ☐ Small (A/B) ☐ Large (D) ☐ Medium (C) ☐ XLarge (DD/E)
☐ Stitched Finger Glove		
Pad (sewn in) ☐ Dorsum ☐ Palm		
Zipper ☐ Dorsum to mid-forearm ☐ Wrist to elbow		☐ Arion Easy Slide (for garment without Stitched Finger Glove)
Arm Sling ☐ Garment ☐ JoViJacket	☐ Dycem®	☐ Prepaid Reduction

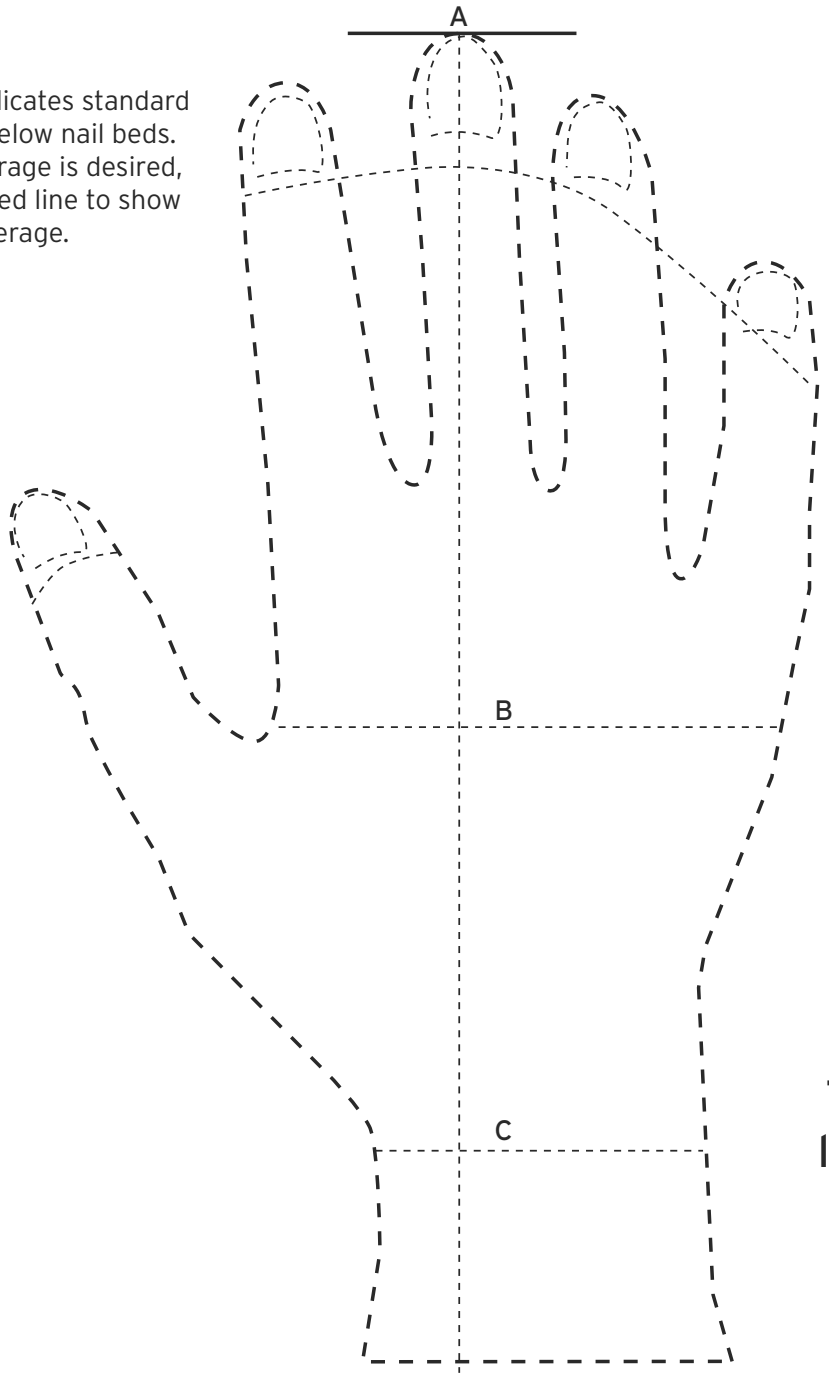
Fitter/Therapist Name: _____ Phone: _____ Email: _____

JOBST JoViPak

CUSTOM HAND TRACING RIGHT HAND

Place hand flat, directly over this guide, palm down, with wrist flexion crease over the C landmark.
Use a black pen to trace around the hand and each finger.

The dotted line indicates standard hand coverage. Below nail beds. If a different coverage is desired, sketch a new dotted line to show that coverage.



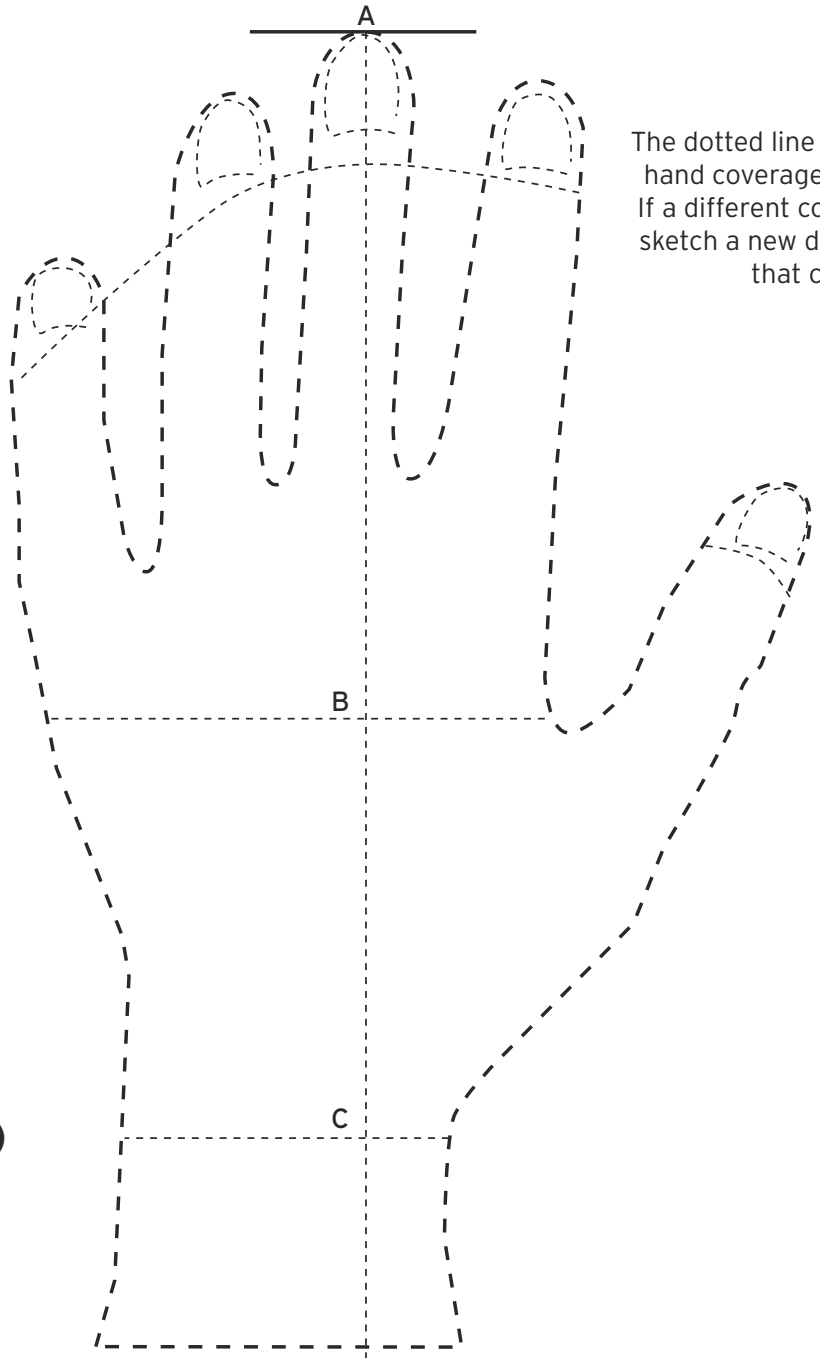
Total hand length (AC)
_____cm

Patient Name or Reference #:_____

JOBST JoViPak

CUSTOM HAND TRACING LEFT HAND

Place hand flat, directly over this guide, palm down, with wrist flexion crease over the C landmark.
Use a black pen to trace around the hand and each finger.



The dotted line indicates standard hand coverage. Below nail beds. If a different coverage is desired, sketch a new dotted line to show that coverage.

Total hand length (AC) _____cm

Patient Name or Reference #:_____

TO ORDER:

JOBST® JoViPak

Vests
Custom

Patient Name:_____

PAYMENT INFORMATION			
Account # (Required)	☐ Bill to Account		Date
☐ Charge Credit Card	☐☐ Card Exp. Date		PO #
Card #			Fax Confirmation #
Name on Card			Email Confirmation

BILLING ADDRESS		SHIPPING ADDRESS ☐ Same as Billing Address	
Business Name		Name	
Attention		Attention	
Address		Address	
City	State	City	State
Phone	Zip	Phone	Zip

ORDER SPECIFICATIONS

☐ Quote ☐ Order

FREE STANDARD SHIPPING



Vest with with optional Full Padding (shown with vertical & horizontal padding options for illustration)



Vest with JoViJacket

Organic Cotton & Spandex Colors			
	QTY		QTY
☐ Black		☐ Ivory	

JoViJacket - Nylon & Spandex Powernet			
	QTY		QTY
☐ Black		☐ White	

(JoViJackets are required to be worn with your JoVi foam garment to ensure maximum fit and effectiveness.)

Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

All sales are subject to JoViPak's Return, Guarantee and Warranty policies

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JOBST JoViPak

Vests
Custom

Patient Name:_____ Previous Patient? ☐ Yes Gender: ☐ F ☐ M

Height*:_____ Weight*:_____ Birthdate: _____

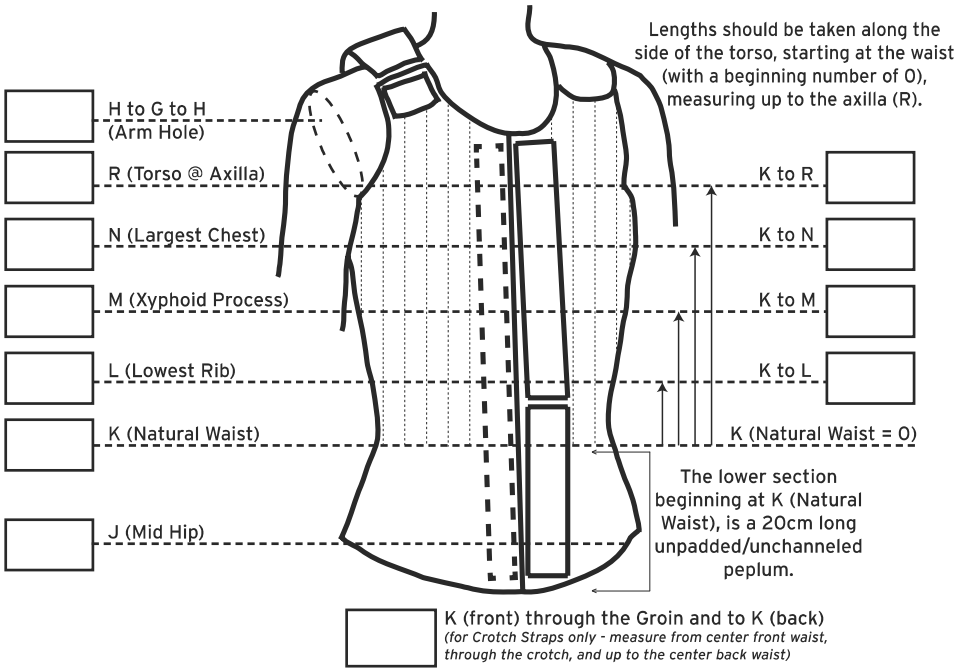
*Height and weight are required.

Must select one: **Mastectomy** ☐ Left ☐ Right **Reconstruction** ☐ Left ☐ Right **Lumpectomy** ☐ Left ☐ Right

Circumference

Please record all measurements in centimeters
All measurements are required.

Lengths



☐ K (front) through the Groin and to K (back)
(for Crotch Straps only - measure from center front waist, through the crotch, and up to the center back waist)

Additional Charge Options

Padded Insert
(equalizes pressure over mastectomy site)
Color: ☐ Black ☐ Buff
Size: ☐ Small (A/B) ☐ Medium (C) ☐ Large (D) ☐ XLarge (DD/E)

☐ Crotch Strap
(helps to keep garment in place for patients with larger abdomens (additional measurements required))

☐ Prepaid Reduction

☐ Full Vertical Padding to natural waist - peplum included

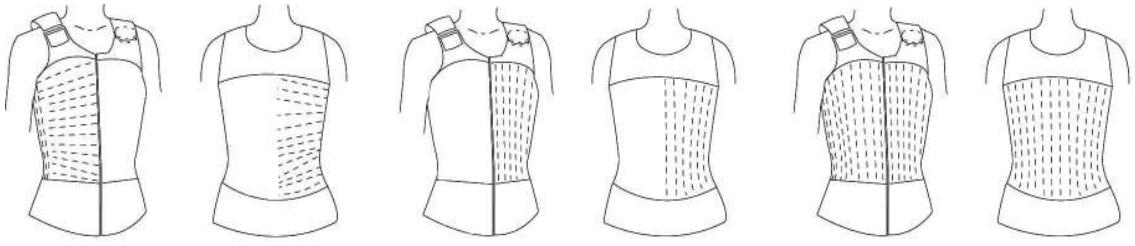
No Charge Options

☐ Slimline *(more channels and less foam)*

☐ Two Blend Foam *(Low ILD)*

☐ End garment at waist *(no peplum)*

Channeling Options



☐ Half Padding Horizontal
☐ Left ☐ Right

☐ Half Padding Vertical
☐ Left ☐ Right

☐ Bilateral Vertical
(additional charge)

Fitter/Therapist Name: _____ Phone: _____ Email: _____

All sales are subject to JoViPak's Return, Guarantee and Warranty policies

Custom Measurement Form for Compression Arm Sleeves & Accessories

Juzo

Scan for How to Measure Videos

Account Information (Please Print)

Account Number	Date Ordered	Phone	Fax	Patient ID	Date Measured
Account Name	Contact		Measured by	Title	P.O. Number
Ship to Address			Prescribing Physician		Re-order #

Order Information

Quantity: _____ Piece(s) ☐ Left ☐ Right

Circular Knit

	18-21 mmHg	23-32 mmHg	34-46 mmHg
☐ Juzo Soft (with silicone) ☐ Beige ☐ Black ☐ White ☐ Chestnut ☐ Trend color _____	☐ 2001	☐ 2002	
☐ Juzo Dynamic ☐ Beige ☐ Black ☐ Chestnut ☐ Trend color _____	☐ 3511	☐ 3512	☐ 3513
	☐ 3561SV	☐ 3562SV	☐ 3563SV
☐ Juzo Dynamic Silver			

Flat Knit

	18-21 mmHg	23-32 mmHg	34-46 mmHg
☐ Juzo Strong	☐ 3051	☐ 3052	☐ 3053
☐ Juzo Strong Silver (Beige)	☐ 3051SV	☐ 3052SV	☐ 3053SV
☐ Juzo Expert	☐ 3021	☐ 3022	☐ 3023
☐ Juzo Expert Silver (Beige)	☐ 3021SV	☐ 3022SV	☐ 3023SV
☐ Juzo Expert Cotton	☐ 3021CO	☐ 3022CO	☐ 3023CO

Circular Knit Styles & Accessories

☐ **CG** ☐ **CH** with shoulder cap and strap ☐ **CH** with shoulder cap and hook & loop to bra (Dynamic)

☐ Beaded silicone border (CG)

Flat Knit Styles & Accessories

☐ **NEW Elbow Functional Zone** (Expert Line)

☐ **CG**
- ☐ Beaded silicone border
- ☐ Slant top (Standard on Strong)
- ☐ Straight top (Standard on Expert)
- ☐ Seam on the outside (with elbow dart)
- ☐ Elbow dart (Standard Strong, typically not needed for Expert)
- ☐ Silver comfort patch (placed on seam side, medial)
- ☐ Smooth comfort patch (placed on seam side, medial)

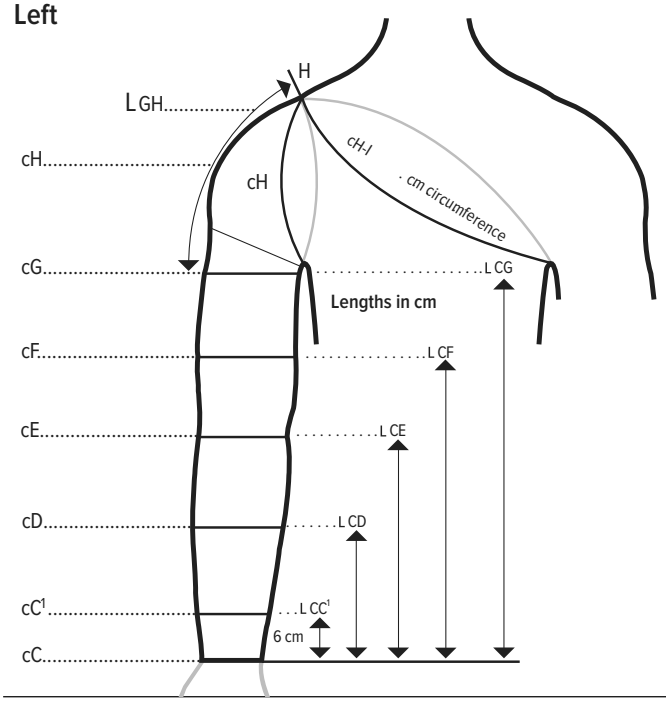
☐ **CH** with shoulder cap and strap
- ☐ Elbow dart (typically not needed for Expert)
- ☐ Silver comfort patch (placed on seam side)
- ☐ Smooth comfort patch (placed on seam side)

☐ **CH** with shoulder cap and velcro to bra
- ☐ Elbow dart (typically not needed for Expert)
- ☐ Silver comfort patch (placed on seam side)
- ☐ Smooth comfort patch (placed on seam side)

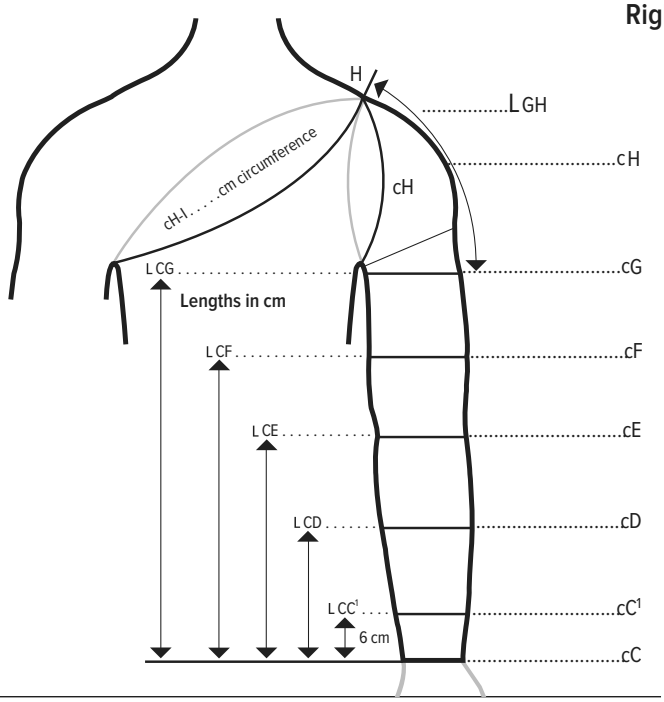
Colors (for Juzo Strong & Juzo Expert)

☐ Beige ☐ Fuchsia ☐ Blue ☐ Dark Blue ☐ Gray ☐ Chestnut ☐ Black ☐ Violet ☐ Trend Color _____

Left



Right



Custom Measurement Form for Gloves / Gauntlets & Accessories

Juzo

Scan for How to Measure Videos

Quantity ..... Piece(s) ☐ Left ☐ Right

	Compression 18-21 mmHg	23-32 mmHg
Juzo® Expert	☐ 3021	☐ 3022
Juzo® Expert Cotton (color beige)	☐ 3021CO	☐ 3022CO
Juzo® Expert Silver (color beige)	☐ 3021SV	☐ 3022SV
Juzo® Strong	☐ 3051	☐ 3052
Juzo® Strong Silver (color beige)	☐ 3051SV	☐ 3052SV

Colors

☐ Beige ☐ Fuchsia ☐ Blue ☐ Gray
☐ Dark blue ☐ Chestnut ☐ Black ☐ Violet ☐ Trend _____

Worn with sleeve: ☐ yes ☐ no

☐ Gauntlet with thumb stub (AC)
☐ Glove with finger stubs(ACFS)
☐ Glove with closed fingers (ACFS)

Accessories

☐ Wrist extension
☐ Pressure pad ☐ regular ☐ extended ☐ sewn in
☐ Attached pocket of pressure pad ☐ dorsal ☐ palm
☐ Silver comfort patch at the thumb webbing
☐ Smooth comfort patch at the thumb webbing

Account Information (Please Print)

Account Number Date

Account Name Contact

Ship to Address

Phone Fax

Patient ID P.O. Number

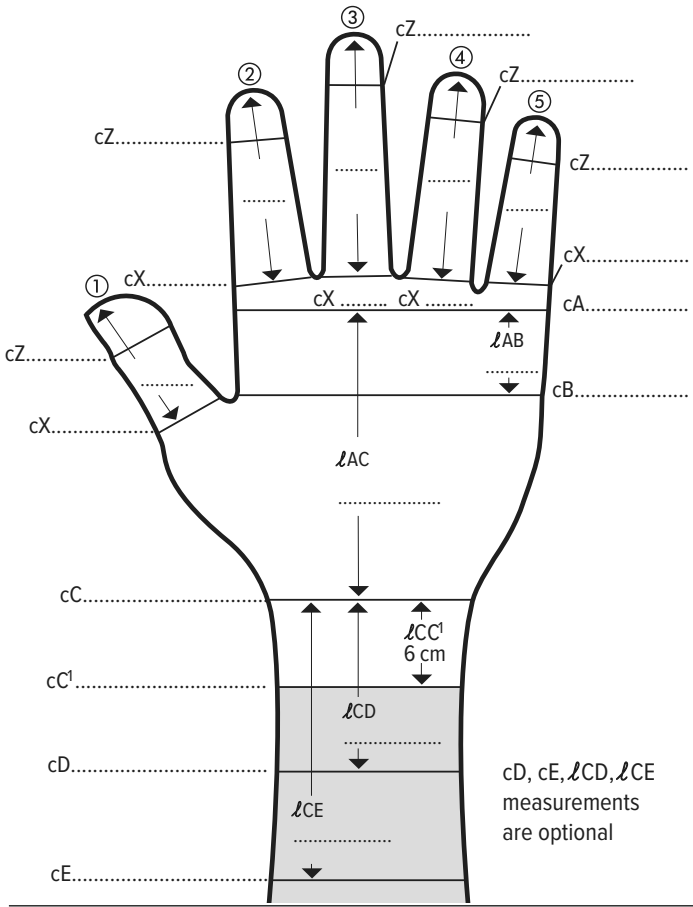
Prescribing Physician

Measured by Title Date Measured

Reorder #

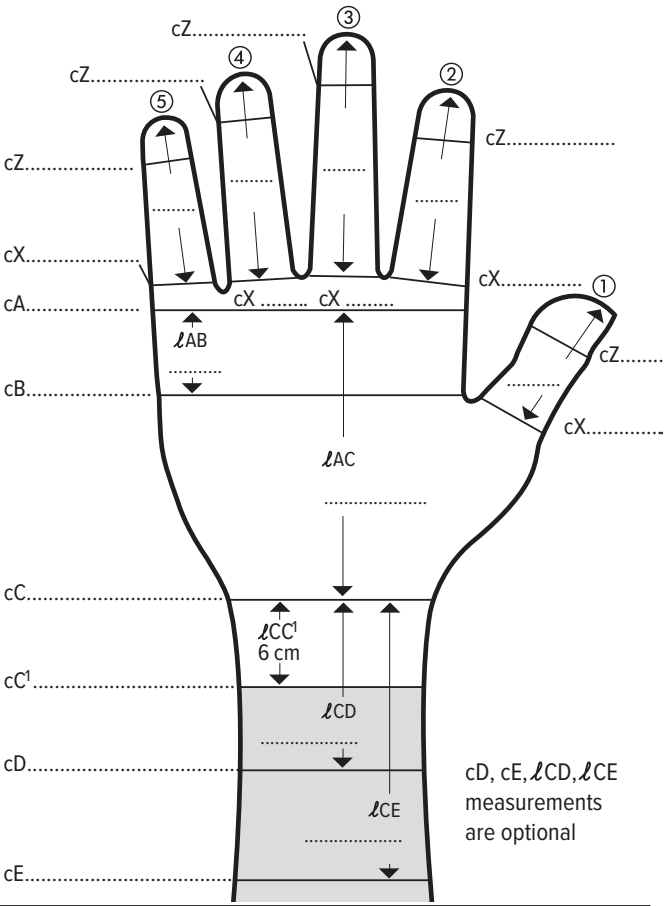
Special requests:

Left



cD, cE, ℓCD, ℓCE measurements are optional

Right



cD, cE, ℓCD, ℓCE measurements are optional

Custom Measurement Form for Flat Knit Stockings & Accessories

Juzo

Account Information (Please Print)

Account Number	Date
Account Name	Contact
Ship to Address	
Phone	Fax
Patient ID	P.O. Number
Prescribing Physician	
Measured by Title	Date Measured

Please Select	18-21 mmHg	23-32 mmHg	34-46 mmHg	50 + mmHg
Expert	❑ 3021	❑ 3022	❑ 3023	❑ 3024
Expert Cotton	❑ 3021CO	❑ 3022CO	❑ 3023CO	
Strong		❑ 3052	❑ 3053	❑ 3054
Expert Silver	❑ 3021SV	❑ 3022SV	❑ 3023SV	❑ 3024SV
Strong Silver	❑ 3051SV	❑ 3052SV	❑ 3053SV	❑ 3054SV

Scan for How to Measure Videos

Re-order #:

Order Information

Quantity:_____ ❑ Pair ❑ Piece(s)

Extremity: ❑ Right ❑ Left ❑ Both

Colors: ❑ Beige ❑ Black ❑ Chestnut ❑ Violet ❑ Blue ❑ Dark Blue ❑ Gray ❑ Fuchsia
(Expert Cotton, Expert Silver, Strong Silver and all 50+ mmHg garments available in beige)

Silver comfort patch: ❑ Behind the knee ❑ Crease of ankle, top of foot

Compression Knee-High & Thigh-High

❑ AD ❑ Straight top border (standard Expert & Strong) ❑ Slant top border

❑ AG ❑ Straight top border (standard Expert) ❑ Slant top border (standard Strong)

❑ 3.5cm Silicone border ❑ 5cm Silicone border

❑ Knee darts (Typically not required for Expert (3020)

❑ Hip attachment (please give "T" circumference)
❑ Right ❑ Left ❑ To be worn as one

❑ K-T body part (open crotch)
❑ 18-21 mmHg ❑ 23-32 mmHg

❑ Slip on ❑ Hook and loop closure, in the front

❑ NEW Knee Functional Zone (Expert Line)

Compression Pantyhose

❑ Standard waist
❑ Border with adjustable waistband
❑ Attached waist belt (non-adjustable)
❑ Pantyhose with leg extension (specify left or right leg)
❑ Mens Gusset ❑ With fly ❑ Open crotch
❑ Capri ❑ Biker short

Foot Portion

❑ Open toe ❑ Closed toe ❑ VY Heel
❑ Slant toe (standard Strong)

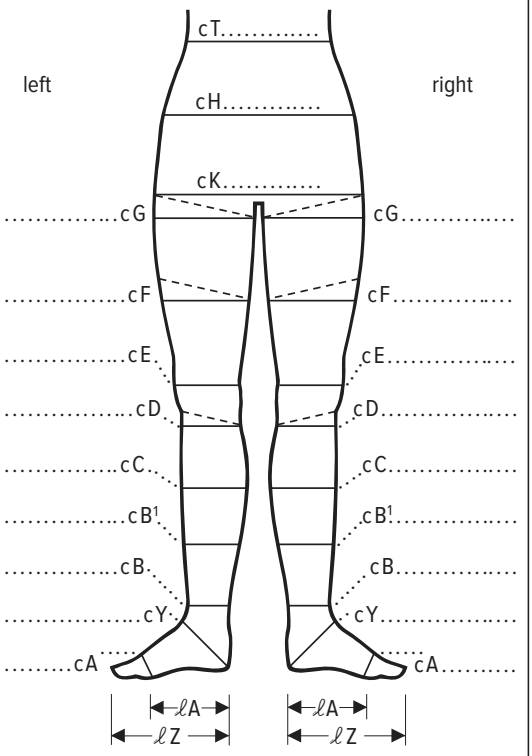
Slant Toe - required measurements

ℓA right medial ..... ℓA right lateral .....

ℓA left medial ..... ℓA left lateral .....

☐ NEW Instep Functional Zone (Expert Line)

Circumference Measurements



❑ **High Rise Back**

KT Front _____

KT Back _____

Lengths

All lengths taken on the medial side of the leg

	left	right
ℓT	.....	.....
ℓH	.....	.....
ℓG/ ℓK	.....	.....
ℓF	.....	.....
ℓE	.....	.....
ℓD	.....	.....
ℓC	.....	.....
ℓB¹	.....	.....
ℓB	.....	.....
ℓA Open Toe	.....	.....
ℓZ Full Foot	.....	.....

Special requests / Notes:

Some additional charges may apply with choosing options

Custom Measurement Form for Compression Foot Portions & Accessories

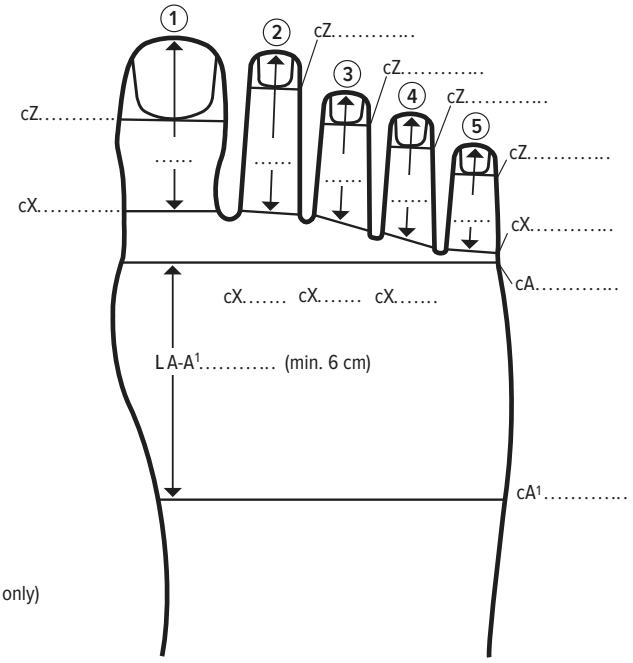
Juzo

Scan for How to Measure Videos

Account Information (Please Print)

Account Number	Date
Account Name	Contact
Ship to Address	
Phone	Fax
Patient ID	Prescribing Physician

Quantity ..... Piece(s) ❒ Left ❒ Right	**Compression** 18-21 mmHg	23-32 mmHg
Juzo Expert (Helastic)	❒ 3021	❒ 3022
Juzo Expert (Helastic) Cotton (color beige)	❒ 3021CO	❒ 3022CO
Juzo Expert (Helastic) Silver (color beige)	❒ 3021SV	❒ 3022SV
Juzo Strong	❒ 3051	❒ 3052
Juzo Strong Silver (color beige)	❒ 3051SV	❒ 3052SV



Colors

❒ Beige ❒ Fuchsia ❒ Blue ❒ Gray ❒ Dark blue ❒ Chestnut
❒ Black ❒ Violet

Options

❒ With open toes ❒ With closed toes ❒ Without toe stub on toe 5 (opening only)
❒ Wear with a compression stocking ❒ Yes ❒ No

Notes:

PCSZ-01-14b

Juzo Custom Measurement Form for Circular Knit Stockings & Accessories

Scan for How to Measure Videos

Account Information (Please Print)

Account Number | Date

Account Name | Contact

Ship to Address

Phone | Fax

Patient ID | P.O. Number

Prescribing Physician

Measured by | Title | Date Measured

Order Information

Quantity:_____ ☐ Pair ☐ Piece(s)

Extremity: ☐ Right ☐ Left ☐ Both

Colors: _____

Styles

☐ AD ☐ AG ☐ AT

Silicone Border

☐ Silicone border

☐ Hip Attachment

☐ Left ☐ Right ☐ Worn as one (need T circumference)

☐ Body Part (worn with AG)

☐ 3021 (18-21 mmHg) ☐ 3022 (23-32 mmHg)
☐ Hook & loop closure
☐ Slip on

Compression Pantyhose

☐ Standard body part
☐ For maternity, measurements taken at____months
☐ Open crotch* ☐ With Fly* (for men)
* Juzo Soft and Dynamic

☐ Compression Pantyhose with Leg Extension*

*Dynamic Line & Soft

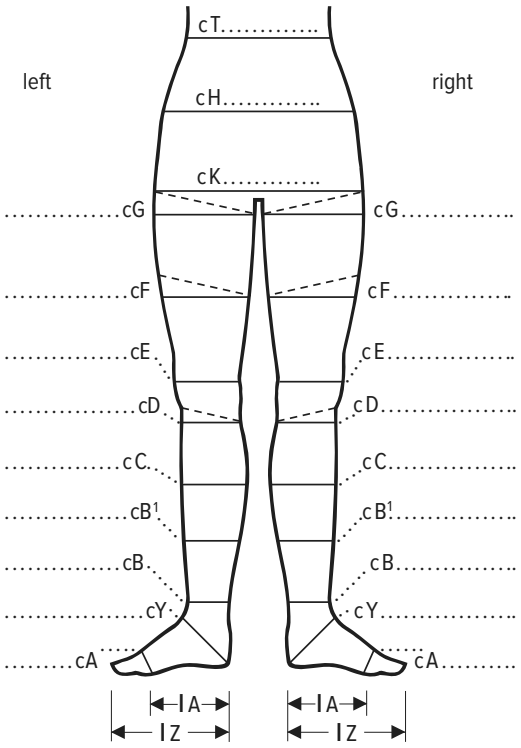
Foot Portion

☐ Open toe ☐ Closed toe

Please Select	18-21 mmHg	23-32 mmHg	34-46 mmHg
Juzo Soft	☐ 2001	☐ 2002	
Juzo Dynamic	☐ 3511	☐ 3512	☐ 3513
Juzo Dynamic Silver	☐ 3511SV	☐ 3512SV	☐ 3513SV
Juzo Move (AD & AG)	☐ 3611	☐ 3612	

Re-order:

Circumference Measurements



Lengths

All lengths taken on the medial side of the leg

	left	right
lT		
lH		
lG/lK		
lF		
lE		
lD		
lC		
lB¹		
lB		
lA Open Toe		
lZ Full Foot		

PCSZ-03-13c

Special request:

Juzo Custom Measurement Form for Compression Face Mask & Accessories

Account Information (Please Print)

Account Number	Date	Re-order#
Account Name	Contact	
Address		
Phone	Fax	
Patient ID	P.O. Number	
Prescribing Physician		

Quantity..... piece(s)	Compression 18-21 mmHg
Juzo® Expert ❑ Beige ❑ Fuchsia ❑ Blue ❑ Gray ❑ Dark Blue ❑ Chestnut ❑ Black ❑ Violet	❑ 3021
Juzo® Expert Silver	❑ 3021SV

Length of the Neck Part
(measured in the front of the neck)

lAB_____cm lBC_____cm lCD_____cm

Length of the Headband
(measured from "D1" over the head to the same point on the opposite side) lD1-D1_____cm lDE_____cm

❑ 

Neck and Chin Bandage

❑ 

Face Mask

Forehead and back of head ❑ open ❑ closed

lEE1_____cm

Openings for: ❑ eyes ❑ nose ❑ mouth

❑ Nose portion knitted according to measurements: M1 = _____cm
M2 = _____cm

Special Request:

PCSZ-01-20c

Neck and Chin Bandage

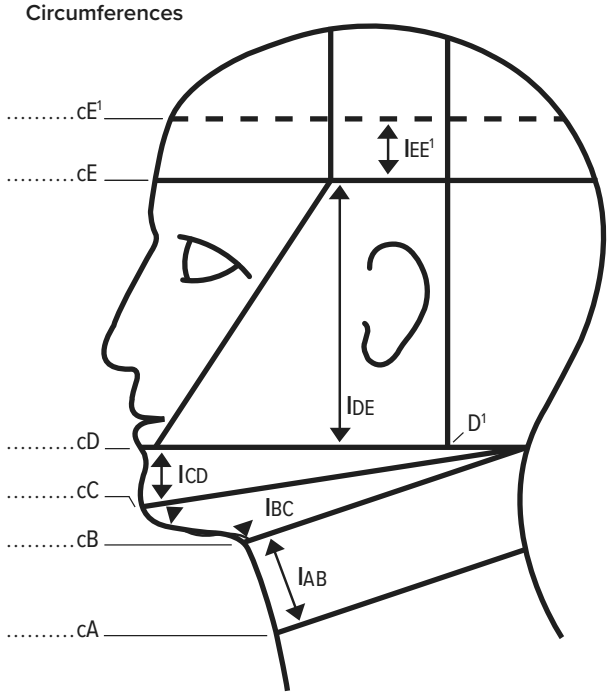
Closure Options

❑ Hook and loop ❑ Hook and eye

Opening for Ears

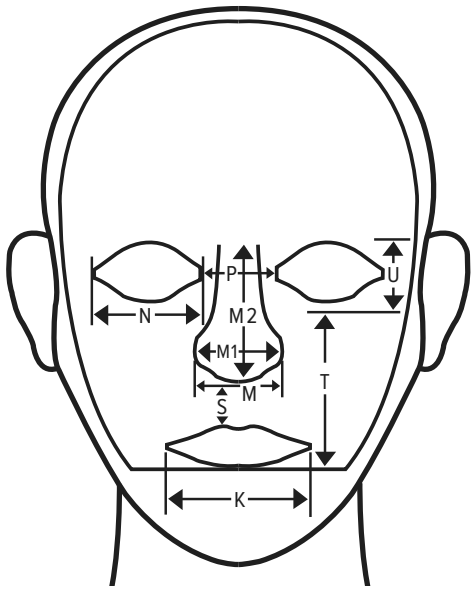
❑ yes ❑ no Height..... cm Width ..... cm

Circumferences



Width and Length Measurements

K = ... cm
M = ... cm
N = ... cm
P = ... cm
S = ... cm
T = ... cm
U = ... cm



Custom Measurement Form for Compression Vests & Accessories

Juzo

Account Information (Please Print)

Account Number | Date | Re-order#

Account Name | Contact

Ship to Address

Phone | Fax

Patient ID | P.O. Number

Prescribing Physician

Quantity..... piece(s)					Compression 18-21 mmHg	Compression 23-32 mmHg
Juzo® Expert	Beige	Fuchsia	Blue	Gray	3021	3022
	Dark Blue	Chestnut	Black	Violet		
Juzo® Expert Silver (beige)					3021SV	3022SV

Styles & Options:

Opening: Mid front Mid back

With zipper With hook & loop closure

Slip on

With arm sleeve

Without arm sleeve

Breast opening, cup size_____

Breast cup seamless, cup size_____

Pocket for prosthetic left right

Stand up collar

Neck circumference_____cm

Stand up collar height_____cm

(In this case, measurements ℓ QU & ℓ RS are not needed)

Attached on a body part of a compression AT pantyhose
(for hook and loop closure at "T" please attach pantyhose measurement form)

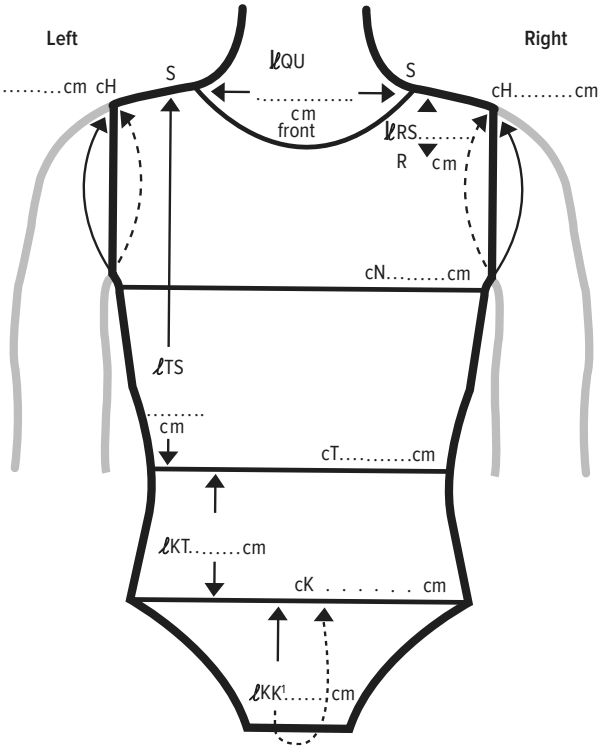
Silicone border at "T"

With crotch panel (KK) (28cm length, 10cm width)

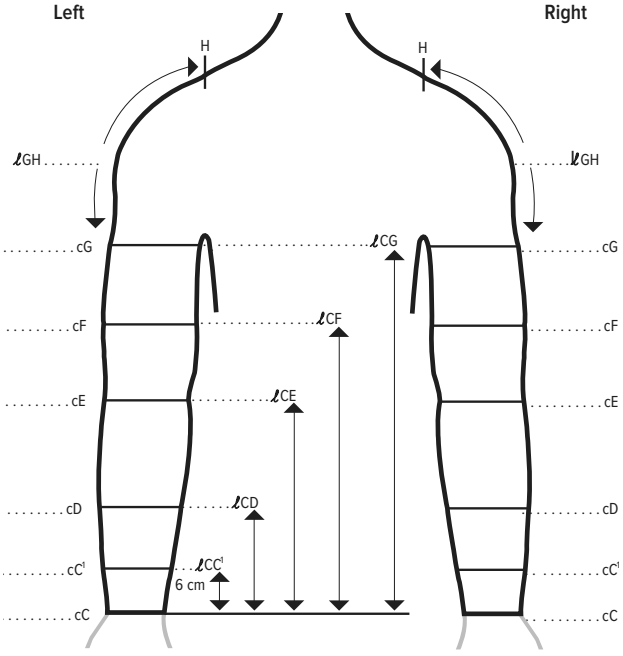
Crotch panel closed wth hook & eye fastener

Special requests:

Vest



Arm Sleeves / Arm Sleeve Extensions



ExoCustom™
Order Information Form

L&R USA INC.
3880 W Wheelhouse Road
Milwaukee. WI 53208

Include this Order Information form with all ExoCustom orders

1. Order Information

Date:	PO #:
☐ Original order ☐ Reorder w/ changes ☐ Exact reorder	
Fax / Email (for confirmation):	
Measured By (for order questions)	
Name:	
Facility:	
Phone / Email:	

2. Client Information

Name / ID:	
Age:	Gender: ☐ Female ☐ Male

3. Billing Information

Account #:	
Bill to:	
Attention:	
Address:	
Address 2:	
City:	
State:	Zip:
Phone:	
Email:	
Credit Card Information (if applicable)	
#:	
Exp Date: /	SID:

Comments

4. Shipping Information ☐ Same as billing address

Ship to:	
Attention:	
Address:	
Address 2:	
City:	
State:	Zip:
Email (for notifications):	
Shipping Method	
☐ Bus Ground ☐ Res Ground ☐ 2nd Day ☐ Overnight	

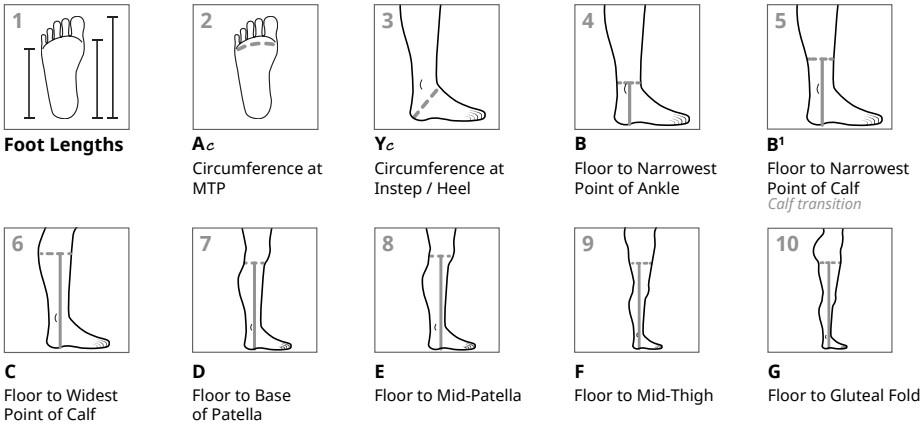
Include this Order Information form with all ExoCustom orders

ExoCustom™
Lower Extremity Measuring and Order Form

L&R USA INC.
3880 W Wheelhouse Road
Milwaukee, WI 53208

Measuring Instructions

- Have a non-toxic washable marker, tape measure, and pen available.
- Measure client after therapy or in the morning.
- Measure with client standing and weight evenly distributed.
- Measure lengths straight, do not follow leg contours.



Ordering Information

Date:	PO:
Customer / Account:	
Client / ID:	
Gender: ☐ Female ☐ Male	
Quantity & Item Code	
Qty	EC–LE– L / R
	EC–LE– L / R
Color: ☐ Beige L / R ☐ Black L / R	
Compression	
☐ 18 - 21mmHg L / R ☐ 23 - 32mmHg L / R	
☐ 34 - 46mmHg L / R	
Distal Foot Options	
Toe: ☐ Closed L / R ☐ Open L / R	
Finish: ☐ Slant L / R ☐ Straight L / R	
Modifications	
Qty	Pocket *(select Place)*
Place: ☐ Back Knee L / R ☐ Instep L / R	
	Silicone *(select Width and Place)*
Width: ☐ 3.5cm L / R ☐ 5cm L / R	
Place: ☐ Inside L / R ☐ 3/4 Inside L / R	
☐ Top L / R	
	Zipper L / R *(note start / end location below)*
Label Placement on Garment	
Place: ☐ Inside L / R ☐ Outside L / R	
Priority Production	
☐	Priority Production *(additional fee)*
Comments	

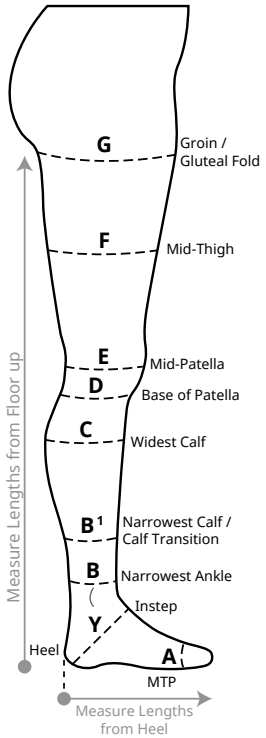
LEFT LEG MEASUREMENTS

	CIRC c	LENGTH ℓ
G	Gc	Gℓ
F	Fc	Fℓ
E	Ec	Eℓ
D	Dc	Dℓ
C	Cc	Cℓ
B1	B1c	B1ℓ
B	Bc	Bℓ
Y	Yc	
A	Ac	

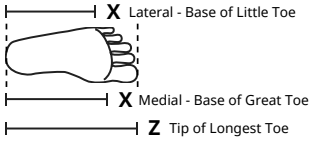
LEFT

Lateral Xℓ Base of Little Toe	
Medial Xℓ Base of Great Toe	
Closed Toe Zℓ Tip of Longest Toe	

Please measure in centimeters



FOOT LENGTH MEASUREMENTS



Foot tracings are always appreciated

RIGHT LEG MEASUREMENTS

	CIRC c	LENGTH ℓ
G	Gc	Gℓ
F	Fc	Fℓ
E	Ec	Eℓ
D	Dc	Dℓ
C	Cc	Cℓ
B1	B1c	B1ℓ
B	Bc	Bℓ
Y	Yc	
A	Ac	

RIGHT

Lateral Xℓ Base of Little Toe	
Medial Xℓ Base of Great Toe	
Closed Toe Zℓ Tip of Longest Toe	

ExoCustom™
Order Information Form

L&R USA INC.
3880 W Wheelhouse Road
Milwaukee. WI 53208

Include this Order Information form with all ExoCustom orders

1. Order Information

Date: | PO #:

☐ Original order ☐ Reorder w/ changes ☐ Exact reorder

Fax / Email (for confirmation):

Measured By (for order questions)

Name:

Facility:

Phone / Email:

2. Client Information

Name / ID:

Age: | Gender: ☐ Female ☐ Male

3. Billing Information

Account #:

Bill to:

Attention:

Address:

Address 2:

City:

State: | Zip:

Phone:

Email:

Credit Card Information (if applicable)

#:

Exp Date: / | SID:

Comments

4. Shipping Information ☐ Same as billing address

Ship to:

Attention:

Address:

Address 2:

City:

State: | Zip:

Email (for notifications):

Shipping Method

☐ Bus Ground ☐ Res Ground ☐ 2nd Day ☐ Overnight

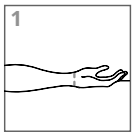
Include this Order Information form with all ExoCustom orders

ExoCustom™
Upper Extremity Measuring and Order Form

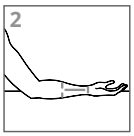
L&R USA INC.
3880 W Wheelhouse Road
Milwaukee, WI 53208

Measuring Instructions

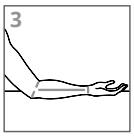
- Have a non-toxic washable marker, tape measure, and pen available.
- Measure client after therapy or in the morning.
- Measure your client's arm with the arm relaxed and slightly bent (≈ 35°), and palm facing up.
- Measure lengths on the medial / inside of the arm, following bend of arm.



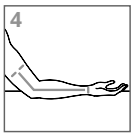
C
Distal Wrist Crease



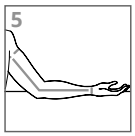
D
Distal Wrist Crease to Mid-Forearm



E
Distal Wrist Crease to Elbow Crease



F
Distal Wrist Crease to Mid-Biceps
Follow bend of arm



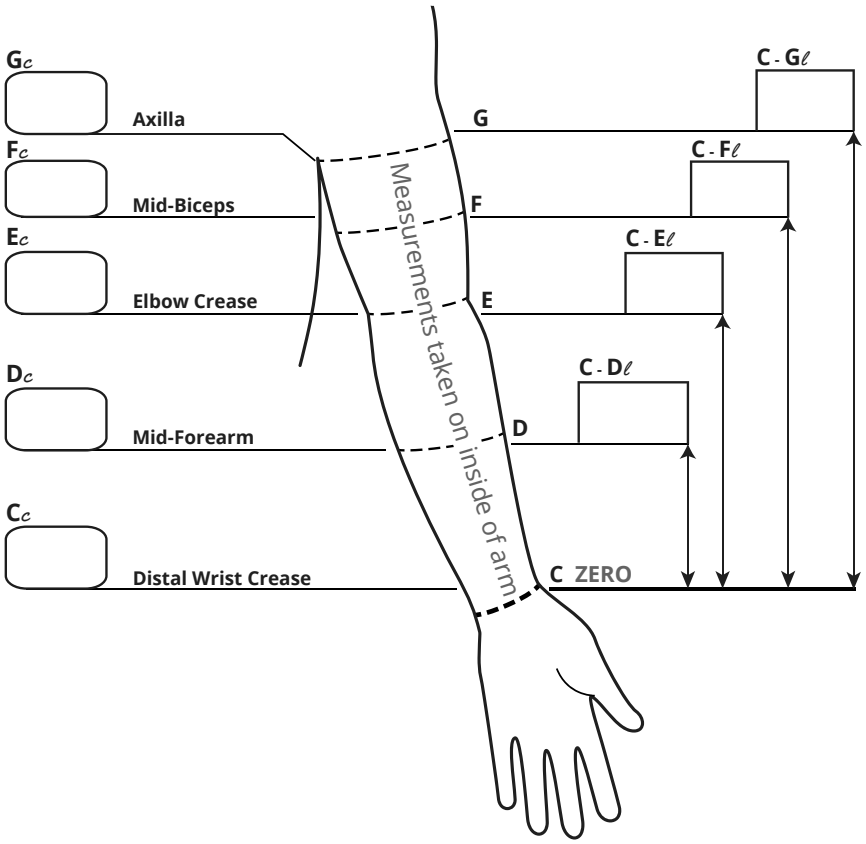
G
Distal Wrist Crease to Axilla
Follow bend of arm

Ordering Information

Date:	PO:
Customer / Account:	
Client / ID:	
Gender: ☐ Female ☐ Male	
Quantity & Item Code	
Qty	EC–UE– L / R
	EC–UE– L / R
Color: ☐ Beige L / R ☐ Black L / R	
Compression	
☐ 18 - 21mmHg L / R ☐ 23 - 32mmHg L / R	
☐ 34 - 46mmHg L / R	
Modifications	
Qty	Pocket - Elbow
	Silicone *(select Width and Place options)*
Width: ☐ 3.5cm L / R ☐ 5cm L / R	
Place: ☐ Inside L / R ☐ 3/4 Inside L / R ☐ Top L / R	
	Zipper L / R *(note start / end location below)*
Label Placement on Garment	
Place: ☐ Inside L / R ☐ Outside L / R	
Priority Production	
	Priority Production *(additional fee)*
Comments	

CIRCUMFERENCE *c* *Please measure in centimeters* **LENGTH** *ℓ*

We suggest that you include additional circumferences and length measurements for more asymetrical shaped arms.



Comfort Care Medical

SEND YOUR COMPLETED ORDER TO
Fax **443.455.1402** Email **orders@comfortcaremd.com**
Questions? **888.358.1580**

L&R

ReadyWrap™ Custom Order Form **LOWER EXTREMITY**

L&R INTERNAL USE ONLY

1 Patient Information

Name: _____ Phone Number: _____ Age: _____ Height: _____ Weight: _____

Therapist/Fitter: Name: _____ Phone Number: _____ Email: _____

2 Garment Design

Extremity Right Left

Style

	Qty. Beige	Qty. Black
Custom Thigh		
Custom Knee		
Custom Calf		
Custom Foot		
Custom Toe (Custom Toe Measurements form must accompany this form.)		

For each ordered, a single appropriately-sized liner will be provided. (Toe garments excluded.) Pairs are available for purchase separately.

Additional Liners (Sold in pairs. Black only.)

QTY.

___ **Below Knee (A–D)** for garments knee and below
___ **Thigh High (A–G)** for garments thigh and below

Liner size will correspond to garments ordered.
To specify size, contact the Custom Design Center.

Special Instructions:

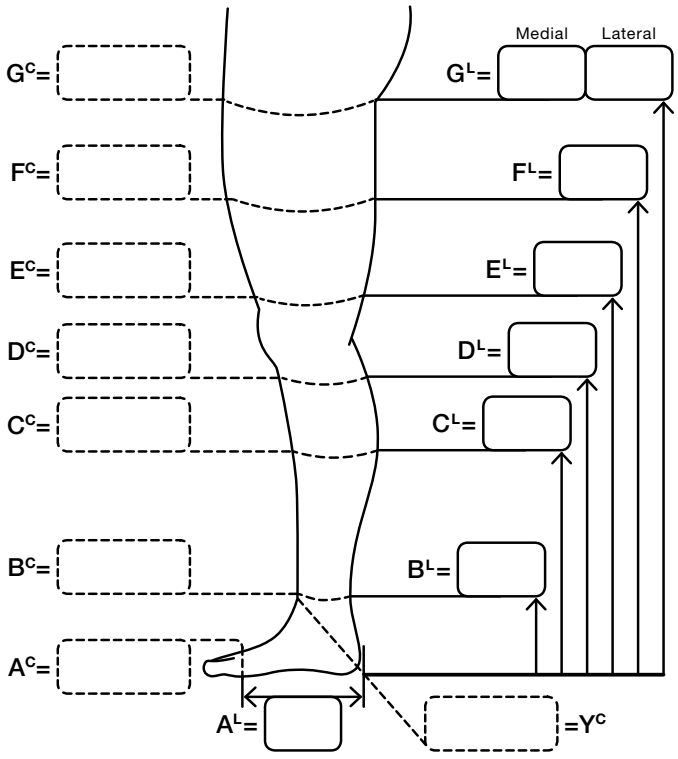
☐Exact Reorder of Order #: _____

3 Measurements

(All measurements in centimeters)

Date taken: ___ / ___ / ___

C = Circumference **L = Length**



Use **Custom Toe Measurements Form** to provide toe measurements.

4 Billing Information

☐Quote Only

Business Name: _____

Phone: _____ Fax: _____

Contact Name & Phone: _____

Account #: _____ P.O. #: _____

Payment: Credit card (provide number below) Net 30

Card #: _____ Exp: ___ /___ SID: ____

5 Shipping Information

Shipping: Standard
Priority Requested Delivery Date: _____

Ship to: _____

Attn: _____

Street: _____

City: _____ State: _____ Province Zip: _____ Postal Code

Phone: _____

Email (for shipping notification): _____

ReadyWrap™ Custom Toe Measurements

This form must be accompanied by a ReadyWrap Custom Lower Extremity Order Form.

1 Order Information

Order Date: _____ /_____ /_____ P.O. #: _____

Contact: _____

Phone: _____ Fax: _____

Email: _____

2 Client Information

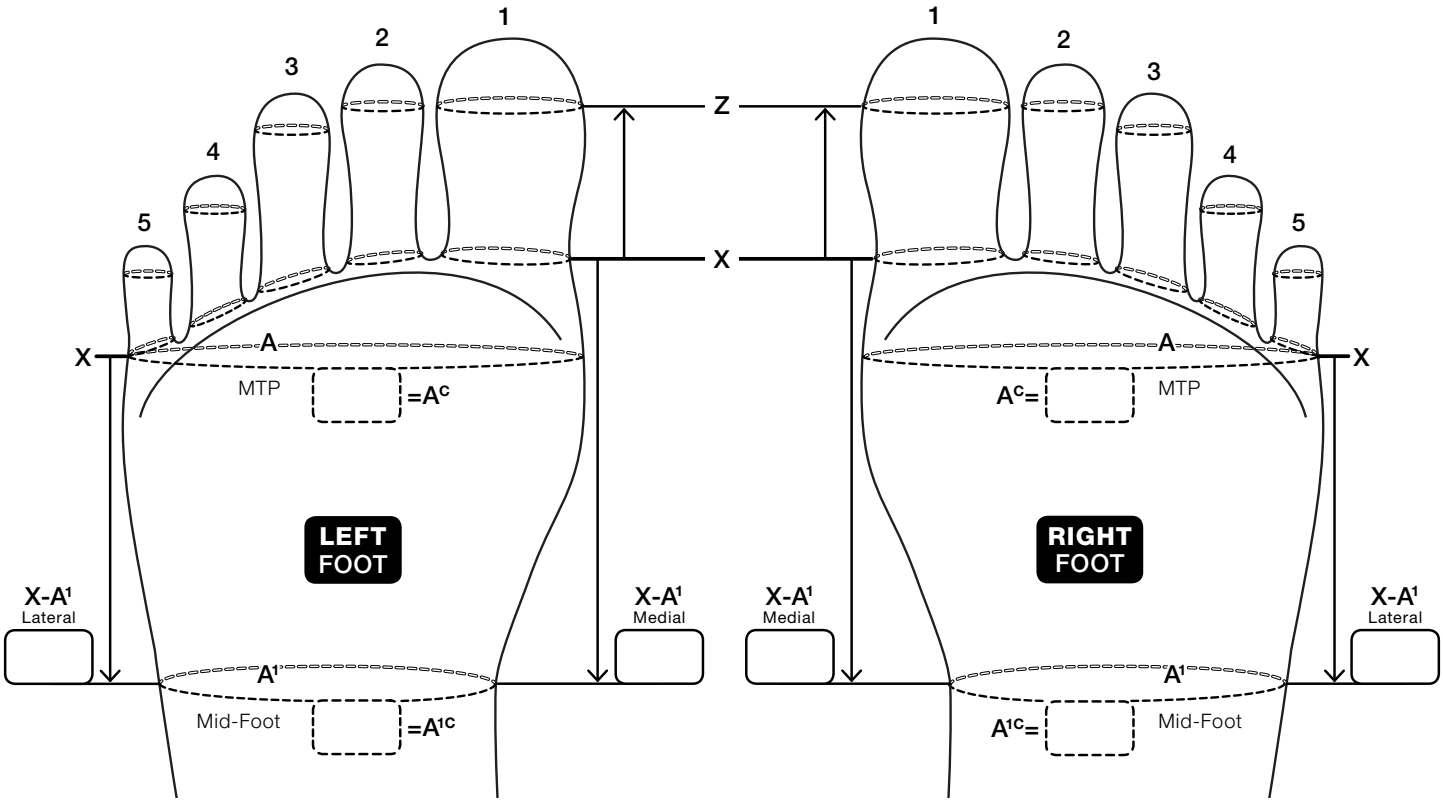
Name: _____

3 Measurements

(All measurements in centimeters)

Date taken: ___ / ___ / ___

	LEFT FOOT						RIGHT FOOT					
	5	4	3	2	1		1	2	3	4	5	
Distal ends of digits						Z^C						Distal ends of digits
Base of digits						X^C						Base of digits
Base to Distal ends						$X–Z^L$						Base to Distal ends



This form must be accompanied by a ReadyWrap Custom Lower Extremity Order Form.

TributeNight™ Arm Order Form

Have questions? Need help?
Talk to a Design Consultant now!
Available M–F, 8:00AM—6:00PM Central.

1 Patient Information

Name: _____ Phone Number: _____ Age: ____ Height: _____ Weight: _____

Therapist/Fitter: Name: _____ Phone Number: _____ Email: _____

2 Garment Design

Style ☐Right Arm ☐Left Arm UE - _____

Channeling ☐Chevron ☐Vertical (Design consult needed)

Fill ☐Chopped Foam ☐Soft Fill

Profile ☐Original ☐Low

Color ☐Black ☐Blue ☐Purple ☐Raspberry ☐Slate

Modifications

QTY.		Notes/Placement Instruction
___	Zippers	
___	Adjustable panels (VELCRO® brand)	
___	Adjustable straps w/Finger grip	
___	Pull-up loops	
___	Digit spacers	
___	Snap tape	
___	Closure (VELCRO® brand)	

Accessories

___ Variable Compression Jacket (VCJ)
___ Outer Jacket (OJ)
- Color: ☐Black ☐Blue ☐Purple ☐Raspberry ☐Slate
- Fastener type: ☐VELCRO® brand fastener ☐Snap

___ Easy Slide Donning Aid

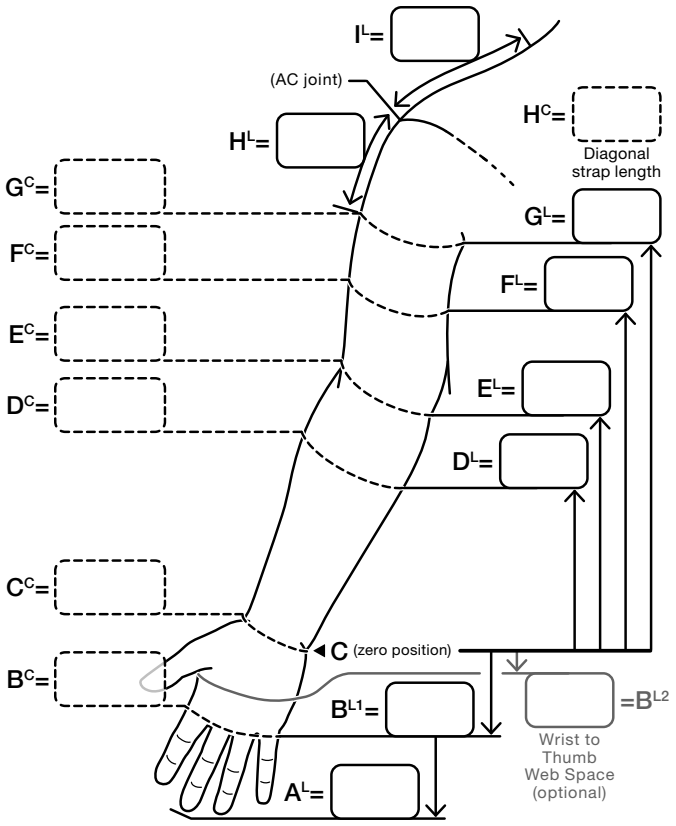
Special Instructions:

☐Exact Reorder of Order #: _____

3 Measurements

(All measurements in centimeters) Date taken: ___ / ___ / ___

^{C} = Circumference ^{L} = Length



4 Billing Information

☐Quote Only

Business Name: _____

Phone: _____ Fax: _____

Contact Name & Phone: _____

Account #: _____ P.O. #: _____

Payment: ☐Credit card (provide number below) ☐Net 30

Card #: _____ Exp: ___ /___ SID: ____

5 Shipping Information

Shipping: ☐Standard
☐Priority Requested Delivery Date: _____

Ship to: _____

Attn: _____

Street: _____

City: _____ State: _____ Province Zip: _____ Postal Code

Phone: _____

Email (for shipping notification): _____

TributeNight™ Head & Neck Order Form

Have questions? Need help?
Talk to a Design Consultant now!
Available M–F, 7:00AM—7:00PM Central.

1 Patient Information

Name: _____ Phone Number: _____ Age: _____ Height: _____ Weight: _____

Therapist/Fitter: Name: _____ Phone Number: _____ Email: _____

2 Garment Design

Style FN - _____

Channeling (Default channeling varies based on garment style.)

Profile ☐Original ☐Low

Color ☐Black (Only available in black.)

Modifications

QTY.		Notes/Placement Instruction
___	Lip bridge	
___	Tracheotomy accommodation	
___	Adjustable panels (VELCRO® brand)	
___	Adjustable straps w/Finger grip ☐Narrow ☐Wide	

Special Instructions:

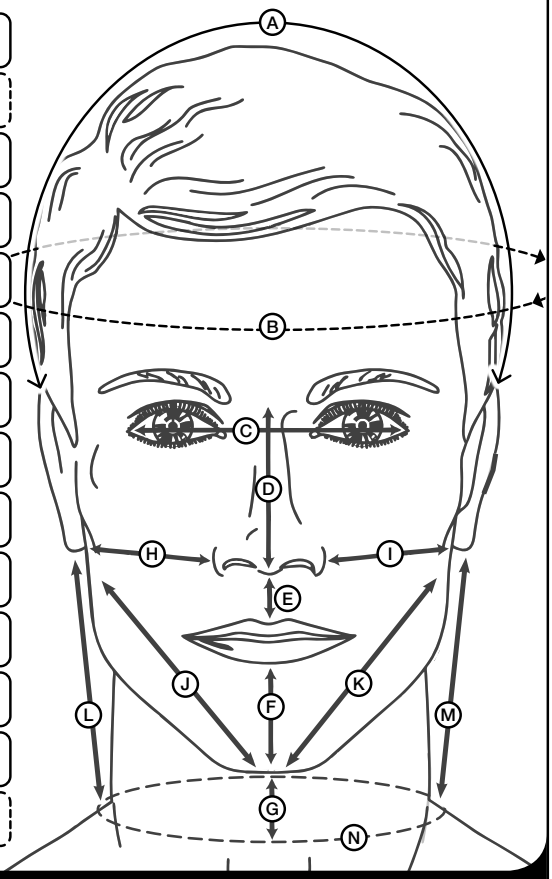
☐Exact Reorder of Order #: _____

3 Measurements

(All measurements in centimeters)

Date taken: ___ / ___ / ___

A^L= B^C= C^L= D^L= E^L= F^L= G^L= H^L= I^L= J^L= K^L= L^L= M^L= N^C=



Denote areas of scarring or fibrosis with hash marks (////).

4 Billing Information

☐Quote Only

Business Name: _____

Phone: _____ Fax: _____

Contact Name & Phone: _____

Account #: _____ P.O. #: _____

Payment: ☐Credit card (provide number below) ☐Net 30

Card #: _____ Exp: ___ /___ SID: ____

5 Shipping Information

Shipping: ☐Standard
☐Priority Requested Delivery Date: _____

Ship to: _____

Attn: _____

Street: _____

City: _____ State: _____ Province Zip: _____ Postal Code

Phone: _____

Email (for shipping notification): _____

TributeNight™ Hand Order Form L

Have questions? Need help?
Talk to a Design Consultant now!
Available M–F, 8:00AM—6:00PM Central.

1 Patient Information

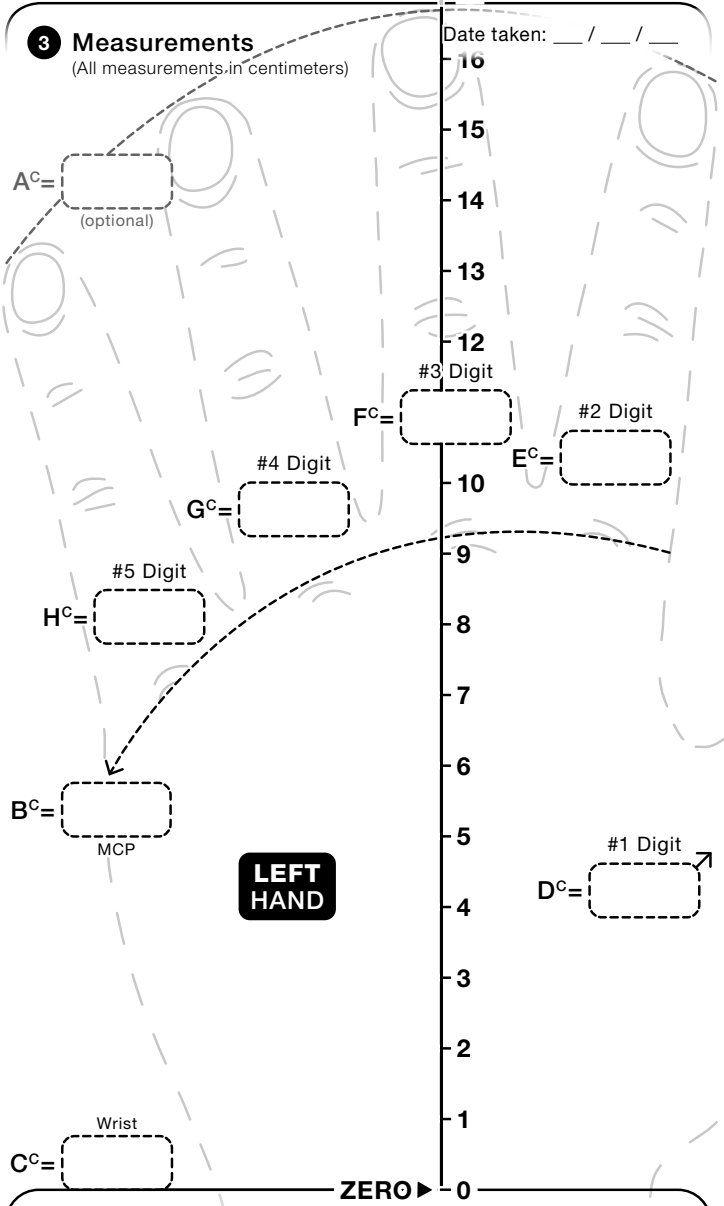
Name: _____ Phone Number: _____ Age: _____ Height: _____ Weight: _____

Therapist/Fitter: Name: _____ Phone Number: _____ Email: _____

3 Measurements

(All measurements in centimeters)

Date taken: ___ / ___ / ___



2 Garment Design

Style UE - _____

Channeling ☐Vertical (Chevron channeling not available.)

Fill ☐Chopped Foam ☐Soft Fill

Profile ☐Original ☐Low

Color ☐Black ☐Blue ☐Purple ☐Raspberry ☐Slate

Modifications

QTY.		Notes/Placement Instruction
___	Zippers	
___	Adjustable panels (VELCRO® brand)	
___	Adjustable straps w/Finger grip	
___	Closure (VELCRO® brand)	

Accessories

___ Outer Jacket (OJ)
- Color: ☐Black ☐Blue ☐Purple ☐Raspberry ☐Slate
- Fastener type: ☐VELCRO® brand fastener ☐Snap

Special Instructions:

☐Exact Reorder of Order #: _____

5 Shipping Information

Shipping: ☐Standard
☐Priority Requested Delivery Date: _____

Ship to: _____

Attn: _____

Street: _____

City: _____ State: _____ (Province) Zip: _____ (Postal Code)

Phone: _____

Email (for shipping notification): _____

4 Billing Information

☐Quote Only

Business Name: _____

Phone: _____ Fax: _____

Contact Name & Phone: _____

Account #: _____ P.O. #: _____

Payment: ☐Credit card (provide number below) ☐Net 30

Card #: _____ Exp: ___ /___ SID: ____

L&R USA INC. will reply with an order confirmation and cost.

TributeNight™ Hand Order Form R

Have questions? Need help?
Talk to a Design Consultant now!
Available M–F, 8:00AM—6:00PM Central.

1 Patient Information

Name: _____ Phone Number: _____ Age: _____ Height: _____ Weight: _____

Therapist/Fitter: Name: _____ Phone Number: _____ Email: _____

2 Garment Design

Style UE - _____

Channeling ☐Vertical (Chevron channeling not available.)

Fill ☐Chopped Foam ☐Soft Fill

Profile ☐Original ☐Low

Color ☐Black ☐Blue ☐Purple ☐Raspberry ☐Slate

Modifications

QTY.		Notes/Placement Instruction
___	Zippers	
___	Adjustable panels (VELCRO® brand)	
___	Adjustable straps w/Finger grip	
___	Closure (VELCRO® brand)	

Accessories

___ Outer Jacket (OJ)
- Color: ☐Black ☐Blue ☐Purple ☐Raspberry ☐Slate
- Fastener type: ☐VELCRO® brand fastener ☐Snap

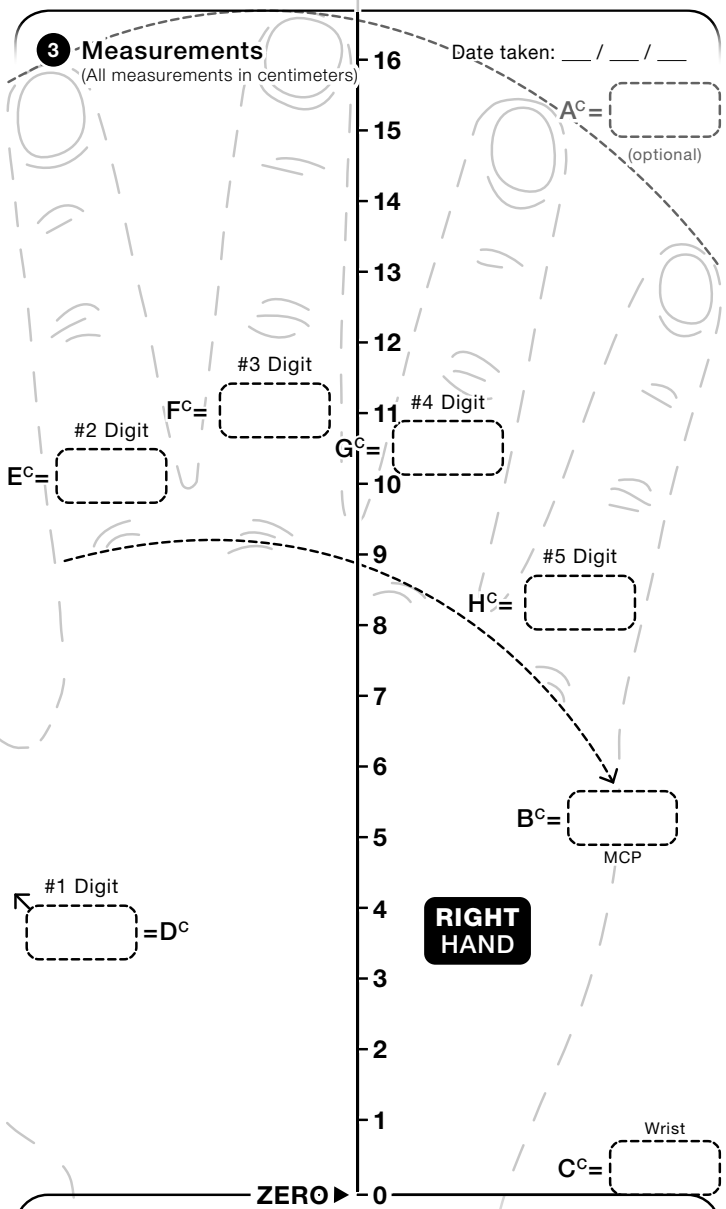
Special Instructions:

☐Exact Reorder of Order #: _____

3 Measurements

(All measurements in centimeters)

Date taken: ___ / ___ / ___



4 Billing Information

☐Quote Only

Business Name: _____

Phone: _____ Fax: _____

Contact Name & Phone: _____

Account #: _____ P.O. #: _____

Payment: ☐Credit card (provide number below) ☐Net 30

Card #: _____ Exp: ___ /___ SID: ___

5 Shipping Information

Shipping: ☐Standard
☐Priority Requested Delivery Date: _____

Ship to: _____

Attn: _____

Street: _____

City: _____ State: _____ Province Zip: _____ Postal Code

Phone: _____

Email (for shipping notification): _____

L&R USA INC. will reply with an order confirmation and cost.

TributeNight™ Leg & Lower Torso Order Form

Have questions? Need help?
Talk to a Design Consultant now!
Available M–F, 8:00AM—6:00PM Central.

1 Patient Information

Name: _____ Phone Number: _____ Age: ____ Height: _____ Weight: _____

Therapist/Fitter: Name: _____ Phone Number: _____ Email: _____

2 Garment Design

Style ☐Right Leg ☐Left Leg LE - _____

Channeling ☐Chevron ☐Vertical

Fill ☐Chopped Foam ☐Soft Fill

Profile ☐Original ☐Low

Color ☐Black ☐Blue ☐Purple ☐Raspberry ☐Slate

Modifications

QTY.		Notes/Placement Instruction
___	Zippers	
___	Adjustable panels (VELCRO® brand)	
___	Adjustable straps w/Finger grip	
___	Non-skid pads	
___	Pull-up loops	
___	Snap tape	
___	Closure (VELCRO® brand)	

Accessories

___ Variable Compression Jacket (VCJ)
___ Outer Jacket (OJ)
- Color: ☐Black ☐Blue ☐Purple ☐Raspberry ☐Slate
- Fastener type: ☐VELCRO® brand fastener ☐Snap
- Modifications: ☐Non-skid pads

___ Easy Slide Donning Aid

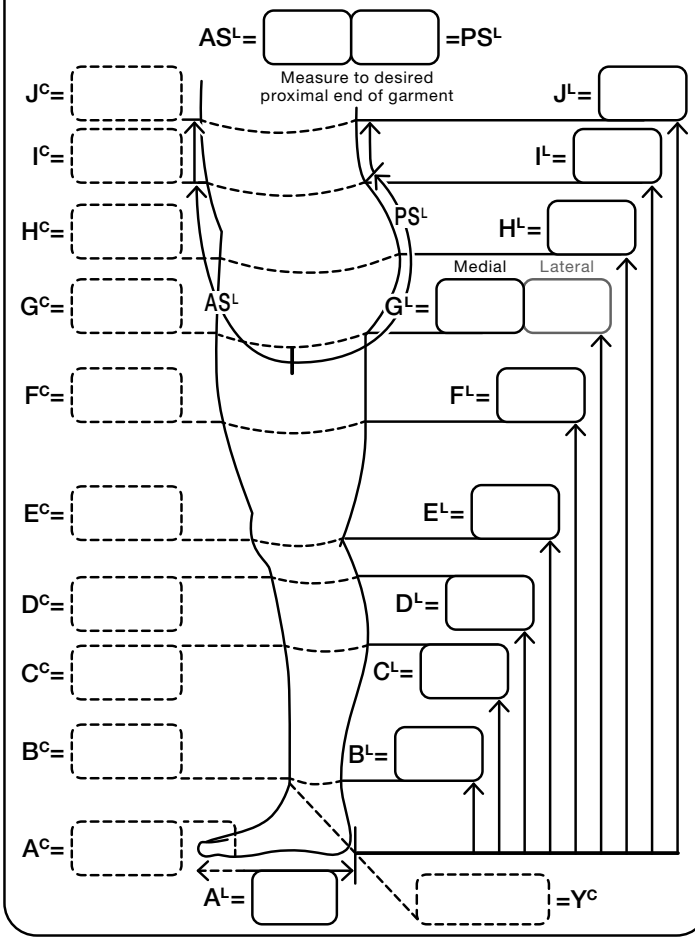
Special Instructions:

☐Exact Reorder of Order #: _____

3 Measurements

Date taken: ___ / ___ / ___

(All measurements in centimeters)



4 Billing Information

☐Quote Only

Business Name: _____

Phone: _____ Fax: _____

Contact Name & Phone: _____

Account #: _____ P.O. #: _____

Payment: ☐Credit card (provide number below) ☐Net 30

Card #: _____ Exp: ___ /___ SID: ____

5 Shipping Information

Shipping: ☐Standard
☐Priority Requested Delivery Date: _____

Ship to: _____

Attn: _____

Street: _____

City: _____ State: _____ Province Zip: _____ Postal Code

Phone: _____

Email (for shipping notification): _____

TributeNight™ Torso Order Form

Have questions? Need help?
Talk to a Design Consultant now!
Available M–F, 8:00AM—6:00PM Central.

1 Patient Information

Name: _____ Phone Number: _____ Age: _____ Height: _____ Weight: _____

Therapist/Fitter: Name: _____ Phone Number: _____ Email: _____

2 Garment Design

Style TT - _____
Breast Tissue Turgor:
☐Firm ☐Moderate Drape ☐Lax

Channeling ☐Chevron (Design consult needed) ☐Vertical

Fill ☐Chopped Foam ☐Soft Fill

Profile ☐Original ☐Low

Color ☐Black ☐Blue ☐Purple ☐Raspberry ☐Slate

Modifications

QTY.		Notes/Placement Instruction
___	Zippers	
___	Adjustable panels (VELCRO® brand)	
___	Adjustable straps w/Finger grip	
___	Snap tape	
___	Closure (VELCRO® brand)	

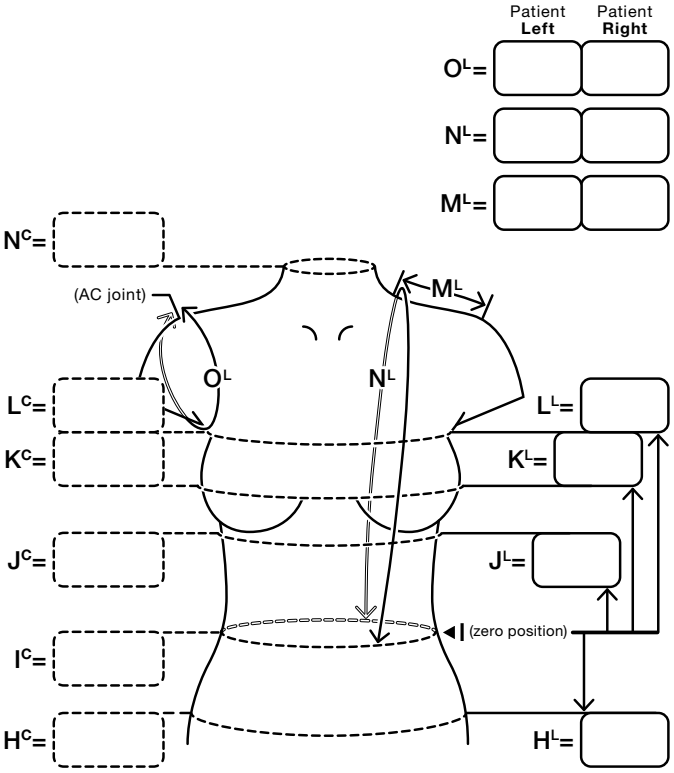
Special Instructions:

☐Exact Reorder of Order #: _____

3 Measurements

(All measurements in centimeters)

Date taken: ___ / ___ / ___



4 Billing Information

☐Quote Only

Business Name: _____

Phone: _____ Fax: _____

Contact Name & Phone: _____

Account #: _____ P.O. #: _____

Payment: ☐Credit card (provide number below) ☐Net 30

Card #: _____ Exp: ___ /___ SID: ____

5 Shipping Information

Shipping: ☐Standard
☐Priority Requested Delivery Date: _____

Ship to: _____

Attn: _____

Street: _____

City: _____ State: _____ Province Zip: _____ Postal Code

Phone: _____

Email (for shipping notification): _____

Tribute™ **Freedom** Arm Order Form

Have questions? Need help?
Talk to a Design Consultant!

1 Patient Information

Name: _____ Phone Number: _____ Age: _____ Height: _____ Weight: _____

Therapist/Fitter: Name: _____ Phone Number: _____ Email: _____

2 Garment Design

Style ☐Right Arm ☐Left Arm

Compression (mmHg)

☐15–20 ☐20–30 ☐30–40 ☐40+ ☐Custom

☐CCL 1 ☐CCL 2 ☐CCL 3

Color ☐Black (Only available in black.)

Modifications

QTY.		Notes/Placement Instruction
___	Zippers	
___	Trim (optional)	
	└☐Lace	
	└☐Lace w/Silicone	
	└☐Silicone dot	
___	Donning loops	
___	Snap tape	
___	Hook & eye	

»» Additional customizations available upon design consult.

Special Instructions:

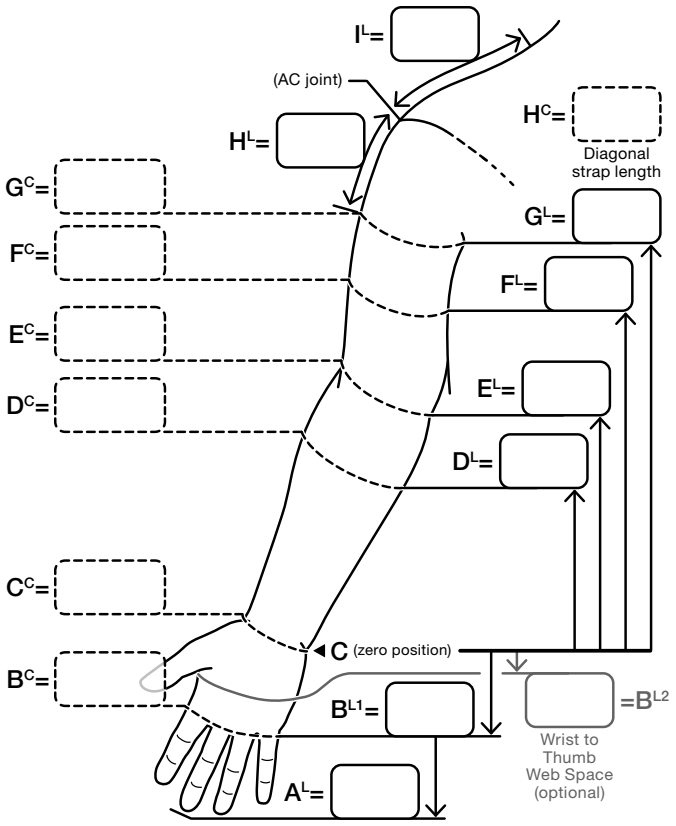
☐Exact Reorder of Order #: _____

3 Measurements

(All measurements in centimeters)

Date taken: ___ / ___ / ___

^{C} = Circumference ^{L} = Length



4 Billing Information

☐Quote Only

Business Name: _____

Phone: _____ Fax: _____

Contact Name & Phone: _____

Account #: _____ P.O. #: _____

Payment: ○Credit card (provide number below) ○Net 30

Card #: _____ Exp: ___ /____ SID: ____

5 Shipping Information

Shipping: ○Standard
○Priority Requested Delivery Date: _____

Ship to: _____

Attn: _____

Street: _____

City: _____ State: _____ Province Zip: _____ Postal Code

Phone: _____

Email (for shipping notification): _____

Tribute™ Freedom Head & Neck Order Form

Have questions? Need help?
Talk to a Design Consultant!

1 Patient Information

Name: _____ Phone Number: _____ Age: _____ Height: _____ Weight: _____

Therapist/Fitter: Name: _____ Phone Number: _____ Email: _____

2 Garment Design

Style

Color ☐Black (Only available in black.)

Modifications

QTY.		Notes/Placement Instruction
___	Lip bridge	
___	Tracheotomy accommodation	

»» Additional customizations available upon design consult.

Special Instructions:

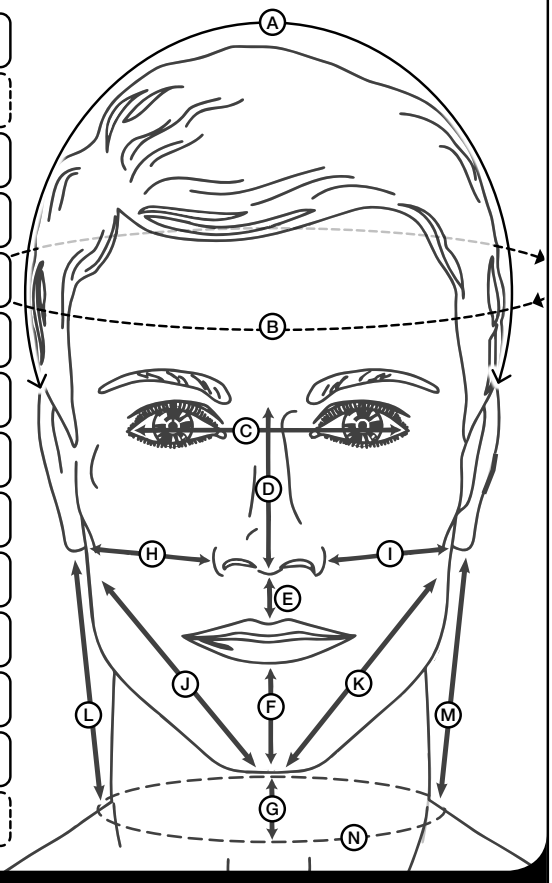
☐Exact Reorder of Order #: _____

3 Measurements

(All measurements in centimeters)

Date taken: ___ / ___ / ___

A^L= B^C= C^L= D^L= E^L= F^L= G^L= H^L= I^L= J^L= K^L= L^L= M^L= N^C=



Denote areas of scarring or fibrosis with hash marks (////).

4 Billing Information

☐Quote Only

Business Name: _____

Phone: _____ Fax: _____

Contact Name & Phone: _____

Account #: _____ P.O. #: _____

Payment: ☐Credit card (provide number below) ☐Net 30

Card #: _____ Exp: ___ /____ SID: ____

5 Shipping Information

Shipping: ☐Standard
☐Priority Requested Delivery Date: _____

Ship to: _____

Attn: _____

Street: _____

City: _____ State: _____ Province Zip: _____ Postal Code

Phone: _____

Email (for shipping notification): _____

Tribute™ Freedom Leg & Lower Torso Order Form

Have questions? Need help?
Talk to a Design Consultant!

1 Patient Information

Name: _____ Phone Number: _____ Age: _____ Height: _____ Weight: _____

Therapist/Fitter: Name: _____ Phone Number: _____ Email: _____

2 Garment Design

Style ☐Right Leg ☐Left Leg

Compression (mmHg)

☐15–20 ☐20–30 ☐30–40 ☐40+ ☐Custom

☐CCL 1 ☐CCL 2 ☐CCL 3 ☐CCL 4

Color ☐Black (Only available in black.)

Modifications

QTY.		Notes/Placement Instruction
___	Zippers	
___	Trim (optional)	
	└☐Lace	
	└☐Lace w/Silicone	
	└☐Silicone dot	
___	Donning loops	
___	Snap tape	
___	Hook & eye	

»» Additional customizations available upon design consult.

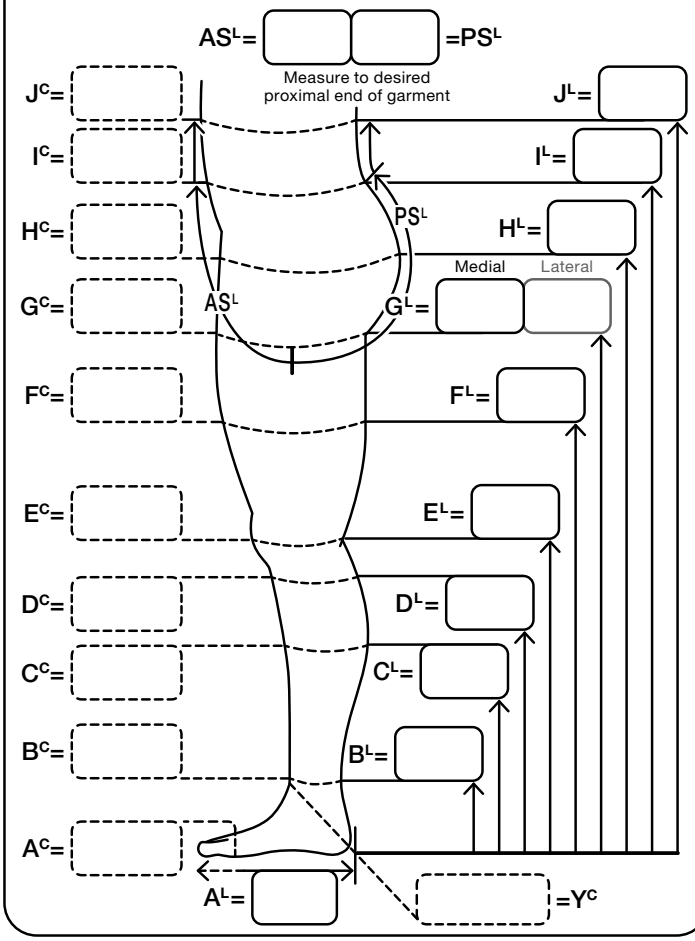
Special Instructions:

☐Exact Reorder of Order #: _____

3 Measurements

Date taken: ___ / ___ / ___

(All measurements in centimeters)



4 Billing Information

☐Quote Only

Business Name: _____

Phone: _____ Fax: _____

Contact Name & Phone: _____

Account #: _____ P.O. #: _____

Payment: ☐Credit card (provide number below) ☐Net 30

Card #: _____ Exp: ___ /____ SID: ____

5 Shipping Information

Shipping: ☐Standard
☐Priority Requested Delivery Date: _____

Ship to: _____

Attn: _____

Street: _____

City: _____ State: _____ Province Zip: _____ Postal Code

Phone: _____

Email (for shipping notification): _____

Tribute™ Freedom Torso Order Form

Have questions? Need help?
Talk to a Design Consultant!

1 Patient Information

Name: _____ Phone Number: _____ Age: _____ Height: _____ Weight: _____

Therapist/Fitter: Name: _____ Phone Number: _____ Email: _____

2 Garment Design

Style Breast Tissue Turgor:
☐Firm ☐Moderate Drape ☐Lax

Color ☐Black (Only available in black.)

Modifications

QTY.		Notes/Placement Instruction
___	Zippers	
___	Trim (optional)	
	└☐Lace	
	└☐Lace w/Silicone	
	└☐Silicone dot	
___	Donning loops	
___	Snap tape	
___	Hook & eye	

»» Additional customizations available upon design consult.

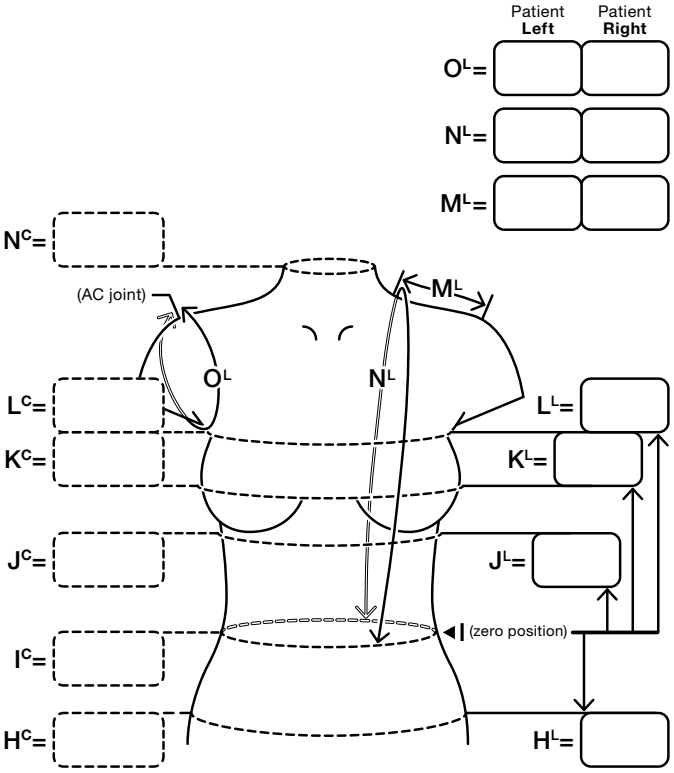
Special Instructions:

☐Exact Reorder of Order #: _____

3 Measurements

(All measurements in centimeters)

Date taken: ___ / ___ / ___



4 Billing Information

☐Quote Only

Business Name: _____

Phone: _____ Fax: _____

Contact Name & Phone: _____

Account #: _____ P.O. #: _____

Payment: ☐Credit card (provide number below) ☐Net 30

Card #: _____ Exp: ___ /____ SID: ____

5 Shipping Information

Shipping: ☐Standard
☐Priority Requested Delivery Date: _____

Ship to: _____

Attn: _____

Street: _____

City: _____ State: _____ Province Zip: _____ Postal Code

Phone: _____

Email (for shipping notification): _____

sigvaris

Armassist®
CUSTOM

Patient Name:	Contact Name:	Height:	Weight:	Date:
Ship Name & Address:	Account Name:	Account #:	P.O #: :	

Product Information

Product includes one Armassist and one pair of Cotton Liners.

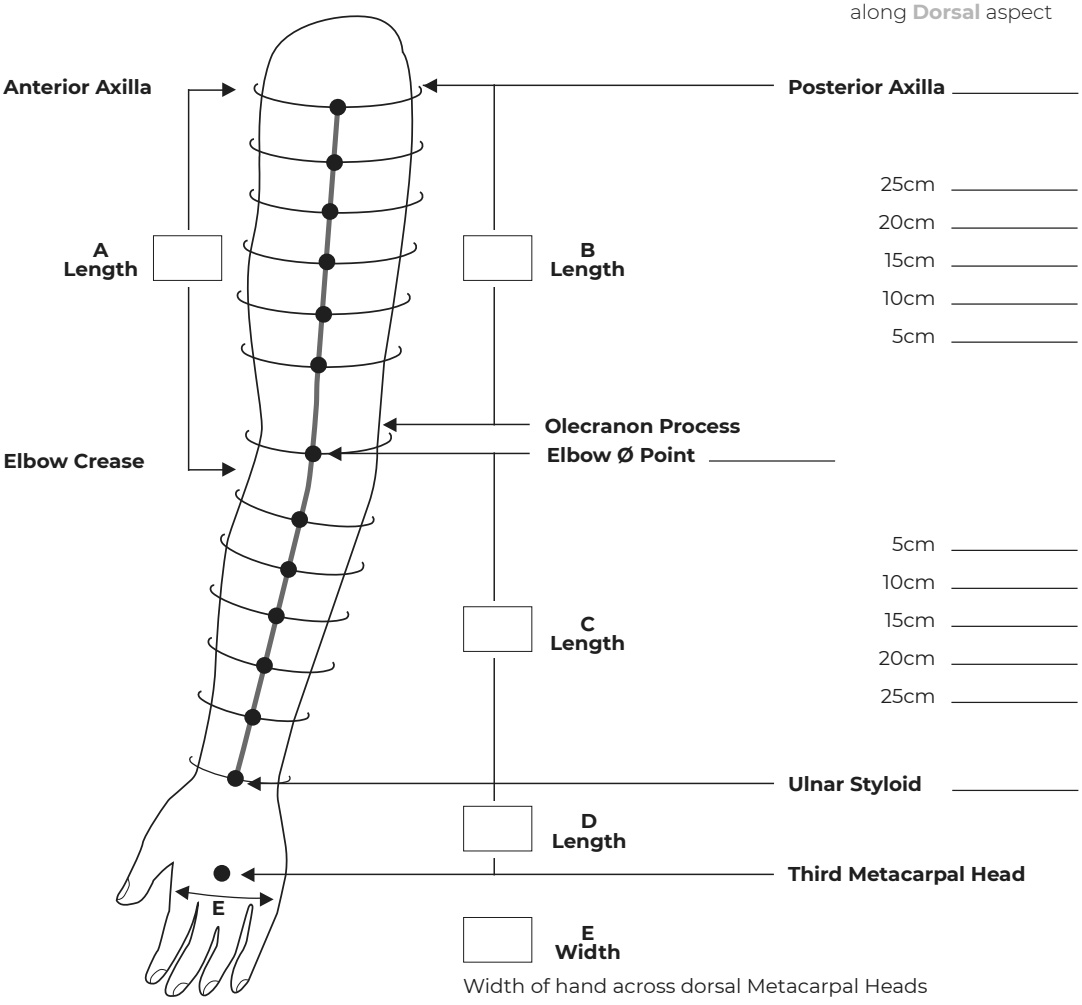
☐ Right Arm
Size: ☐ Regular ☐ Super

☐ Left Arm
Size: ☐ Regular ☐ Super

Foam
☐ Flat
☐ Wavefoam

Circumference Measurements

● = Locations measured along **Dorsal** aspect



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sigvaris

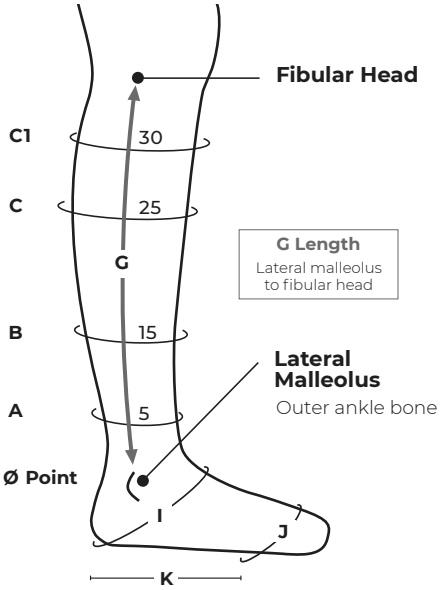
Chipflow®

CALF & FOOT CUSTOM

Patient Name:	Contact Name:
Account Name:	Account #:
Account Phone #:	P.O. #:
Ship Name & Address:	Date:

Circumference

	Left	Right
C1		
C		
B		
A		
G		
I		
J		
K		



Product Information

Product includes one custom Chipflow Calf, one Compreboot® Standard Foot wrap, one Chip Foam Liner, and one pair of Non-compressive Basic Liners*.

☐ Right Calf	Color: Black	Quantity:
☐ Right Foot	Color: Black:	Quantity:
☐ Left Calf	Color: Black	Quantity:
☐ Left Foot	Color: Black:	Quantity:

*For the largest size, a pair of Non-compressive Cotton Liners is included instead of the Basic Liners.

Important

Exact measurements are critical for this garment to ensure a proper fit. If you have questions about measuring for this garment or would like assistance with measuring and fitting this garment please contact

Supplies needed

- Measuring instructions and forms.
- SIGVARIS GROUP Measuring tape and body pen (or eyeliner pencil).

Chipflow Calf Size Chart (A–C1)

Note: Product contains Measurement Limitations with Min & Max sizing for ankle and calf

	Min	Max
C1	31cm	69cm
C	31cm	69cm
B	26cm	59cm
A	19cm	51cm
Black		
G Length	27cm	42cm

Measurement Disclaimer

Max calf < 2x ankle

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Chipflow®

FULL LEG CUSTOM

Patient Name:	Contact Name:
Account Name:	Account #:
Account Phone #:	P.O. #:
Ship Name & Address:	Date:

Product Information

Product includes one custom Chipflow Full leg, one Compreboot® Standard Foot wrap, one Chip Foam Liner, and one pair of Non-compressive Cotton Liners.

☐ Right Leg	Color: Black	Quantity:
☐ Right Foot	Color: Black:	Quantity:
☐ Left Leg	Color: Black	Quantity:
☐ Left Foot	Color: Black:	Quantity:

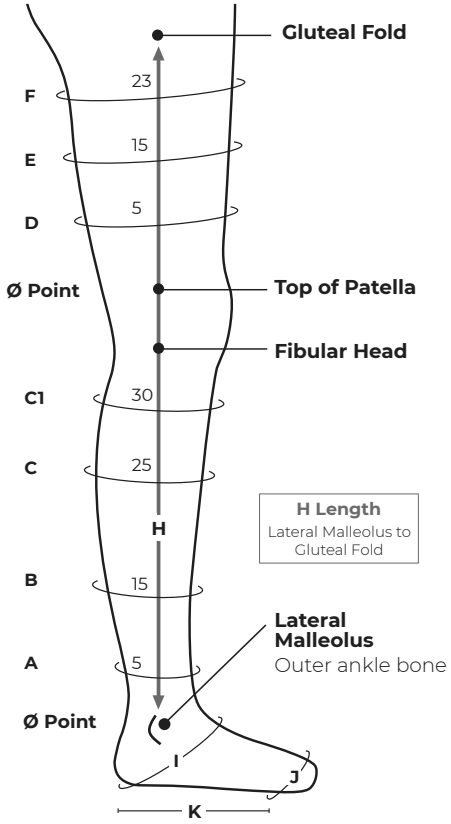
Important

Exact measurements are critical for this garment to ensure a proper fit. If you have questions about measuring for **this garment or would** like assistance with measuring and fitting this garment please contact

Supplies needed

- Measuring instructions and forms.
- SIGVARIS GROUP Measuring tape and body pen (or eyeliner pencil).

Circumference	Left	Right
F		
E		
D		
C1		
C		
B		
A		
H		
I		
J		
K		



Chipflow Full Leg Size Chart (A–C1)

Note: Product contains Measurement Limitations with Min & Max sizing for ankle, calf, and thigh

	Min	Max
F	48cm	90cm
E	43cm	84cm
D	38cm	81cm
C1	31cm	69cm
C	31cm	69cm
B	26cm	59cm
A	19cm	51cm
Black		
H Length	66cm	91cm
Measurement Disclaimer		
	Max thigh < 2x calf	Max calf < 2x ankle

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Chipsleeve® Custom

ARM

Patient Name:	Contact Name:
Account Name:	Account #:
Account Phone #:	P.O. #:
Item #: 2739-AR Height:	Weight:
Ship Name & Address:	Date:

Product Information

Product includes one Chipsleeve Custom Arm, one pair of Cotton Liners, and one black Oversleeve.

☐ Right Arm	Color: Black
☐ Left Arm	Color: Black

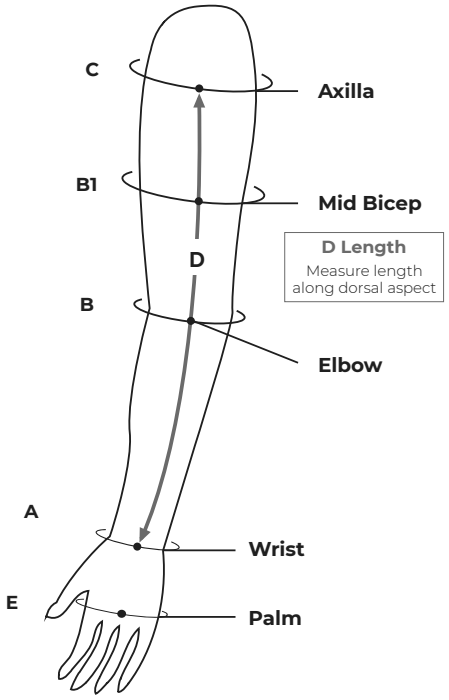
Circumference

	Left	Right
C		
B1		
B		
A1		
A		
E		

D Length

Measure length along dorsal aspect

D _____ _____



Important

Exact measurements are critical for this garment to ensure a proper fit. If you have questions about measuring for **this garment or would** like assistance with measuring and fitting this garment please contact

Measurement disclaimer for this product:
Axilla (C) measurement must be < 54 cm.

Supplies needed

- Cell phone with camera. Photos of the arm with measurement markings must be emailed to:
- Measuring instructions and forms.
- SIGVARIS GROUP Measuring tape and body pen (or eyeliner pencil).

Measuring Instructions

With patient seated, place the arm extended and elbow bent slightly, with the palm down, on a flat surface.

Circumferences

- Measure circumference at palm and record on line E.
- Measure circumference at wrist, and record on line A.
- Mark dorsal aspect at distal edge of tape.
- Measure circumference at forearm, and record on line A1.
- Measure circumference at elbow, and record on line B.
- Measure circumference at mid bicep, and record on line B1.
- Measure circumference at axilla, and record on line C.
- Mark dorsal aspect at proximal edge of tape.

Length

Measure length at dorsal aspect from mark at Point A to mark at Point C and record in box D.

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Chipsleeve® Custom

CALF AND FOOT

Patient Name:	Contact Name:
Account Name:	Account #:
Account Phone #:	P.O. #:
Item #: 2739-BK Height:	Weight:
Ship Name & Address:	Date:

Product Information

Product includes one Chipsleeve Custom Calf & Foot, one pair of Non-compressive Basic Liners, and one black Oversleeve.

☐ Right Calf	Size:	Item #:
Color: Black	Length:	Quantity:
☐ Left Calf	Size:	Item #:
Color: Black	Length:	Quantity:

Important

Exact measurements are critical for this garment to ensure a proper fit. If you have questions about measuring for **this garment or would** like assistance with measuring and fitting this garment please contact

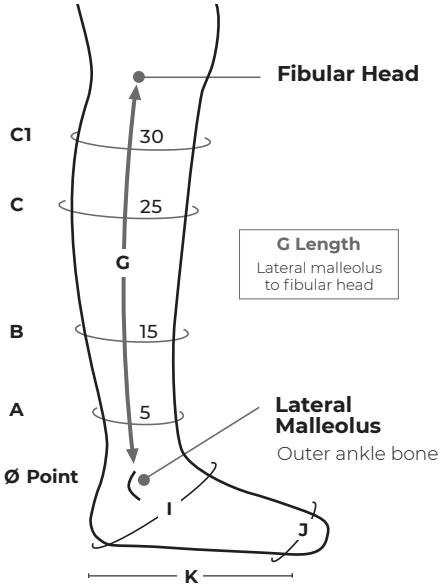
Measurement disclaimer for this product:
Max calf (C) measurement must be < 68 cm.

Supplies Needed

- Cell phone with camera. Photos of the arm with measurement markings must be emailed to:
- Measuring instructions and forms.
- SIGVARIS GROUP Measuring tape and body pen (or eyeliner pencil).

Circumference	Left	Right
C1		
C		
B		
A		
I		
J		
G		
K		

G Length
Regular: 30–33.9cm
Tall: 34–42cm



Measuring Instructions

With patient standing on flat surface measure the lateral aspect of leg.

Circumferences

- Measure circumference of ankle bend and heel and record on line I.
- Measure circumference across metatarsal heads and record on line J.
- Measure circumference at the 5cm and record online A.
- Measure circumference at the 15cm and record online B.
- Measure circumference at the 25cm and record online C.
- Measure circumference at the 30cm and record online C1.
- Mark lateral aspect at proximal edge of tape.

Length

Measure length from lateral malleolus to the bottom of the fibular head and place marks for circumference measurements on the 5cm, 15cm, 25cm and 30cm. Record the length online G. Measure length on medial side of foot from heel to 1st metatarsal head and record on line K.

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Chipsleeve® Custom

FULL LEG

Patient Name:	Contact Name:
Account Name:	Account #:
Account Phone #:	P.O. #:
Item #: 2739-TH Height:	Weight:
Ship Name & Address:	Date:

Product Information

Product includes one Chipsleeve Full Leg, one pair of Cotton Liners, and one black Oversleeve.

☐ Right Leg	Size:	Item #:
Color: Black	Length:	Quantity:
☐ Left Leg	Size:	Item #:
Color: Black	Length:	Quantity:

Important

Exact measurements are critical for this garment to ensure a proper fit. If you have questions about measuring for **this garment or would** like assistance with measuring and fitting this garment please contact

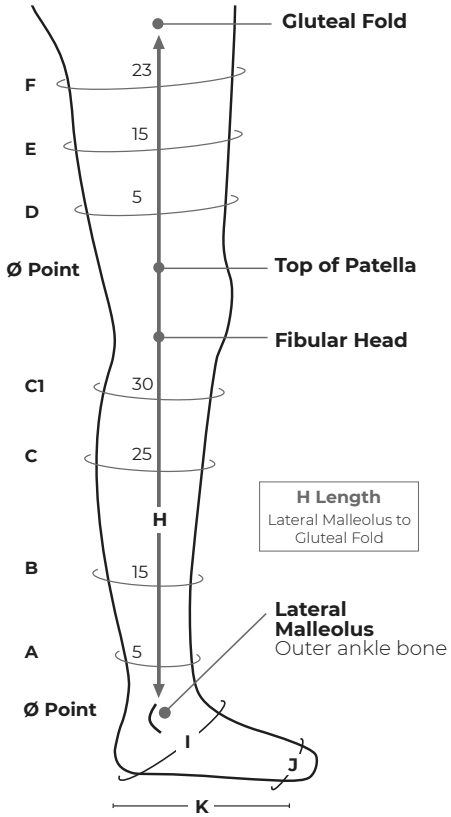
Measurement disclaimer for this product:
Max thigh (F) measurement must be < 84 cm.

Supplies needed

- Cell phone with camera. Photos of the arm with measurement markings must be emailed to:
- Measuring instructions and forms.
- SIGVARIS GROUP Measuring tape and body pen (or eyeliner pencil).

Circumference	Left	Right
F		
E		
D		
C1		
C		
B		
A		
I		
J		
H		
K		

H Length
Short: 61–70.9cm
Regular: 71–80.9cm
Tall: 81–91cm



K Length: Measure **medial** length from heel to 1st metatarsal head

Measuring Instructions

With patient standing on flat surface measure the lateral aspect of leg.

Circumferences:

- Measure circumference of ankle bend and heel and record on line I.
- Measure circumference across metatarsal heads and record on line J.
- Measure circumference at the 5cm and record online A.
- Measure circumference at the 15cm and record online B.
- Measure circumference at the 25cm and record online C.
- Measure circumference at the 30cm and record online C1.
- Measure circumference 5cm above patella and record online D.
- Measure circumference 15cm above patella and record online E.
- Measure circumference 23cm above patella and record online F.
- Mark lateral aspect at proximal edge of tape.

Length

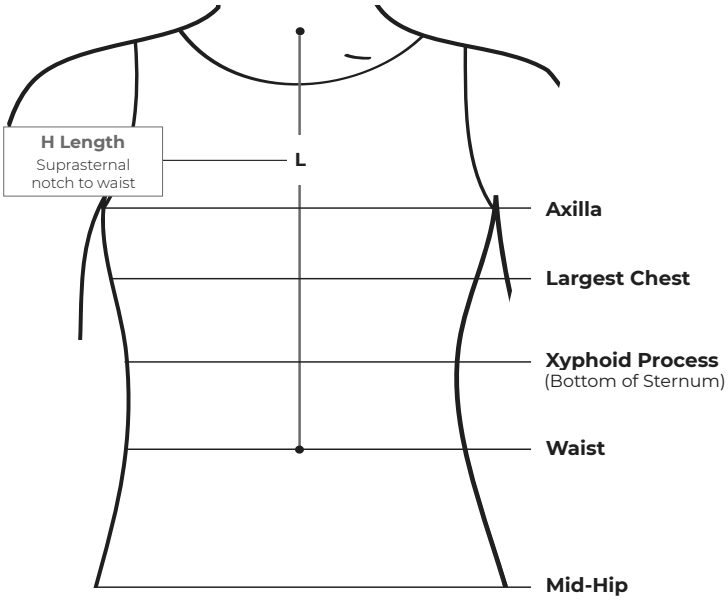
Measure length from lateral malleolus to the Gluteal Fold and place marks for circumference measurements on the 5cm, 15cm, 25cm, 30cm, from the malleolus and 5cm, 15cm, 23cm, above the patella. Record the length on line H. Measure length on medial side of foot from heel to 1st metatarsal head and record on line K.

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Chipvest®
CUSTOM

Patient Name:	Contact Name:
Account Name:	Account #:
Account Phone #:	P.O. #:
Height:	Weight:
Ship Name & Address:	Date:



Product Information

Product includes one Chipvest Custom.

Custom Chipvest Item #: **2239-VS**

- ☐ Full (Bilateral)
- ☐ Right Side (unilateral)
- ☐ Left Side (unilateral)

Measuring Instructions

Step 1:
Measure the length in centimeters from the suprasternal notch to the waist.

Step 2:
Measure circumferences in centimeters.

Important

Exact measurements are critical for this garment to ensure a proper fit. If you have questions about measuring for **this garment or would** like assistance with measuring and fitting this garment please contact

Measurement disclaimer for this product:
Max chest (B) measurement must be < 131 cm.

Custom Size Measurments

Length	Centimeters
L	
Circumference	**Centimeters**
Axilla	
Largest Chest	
Xyphoid Process	
Waist	
Mid-Hip	

Supplies needed

- Cell phone with camera. Photos of the arm with measurement markings must be emailed to:
- Measuring instructions and forms.
- SIGVARIS GROUP Measuring tape and body pen (or eyeliner pencil).

Caution:
Drawstring contains natural rubber latex which may cause allergic reactions.

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Compreshort®

CUSTOM

Patient Name:	Contact Name:
Height	Weight
Account Name:	Account #:
Account Phone #:	P.O. #:
Ship Name & Address:	Date:

Circumference

E Waist _____

D Hip _____

C2 Midthigh L _____

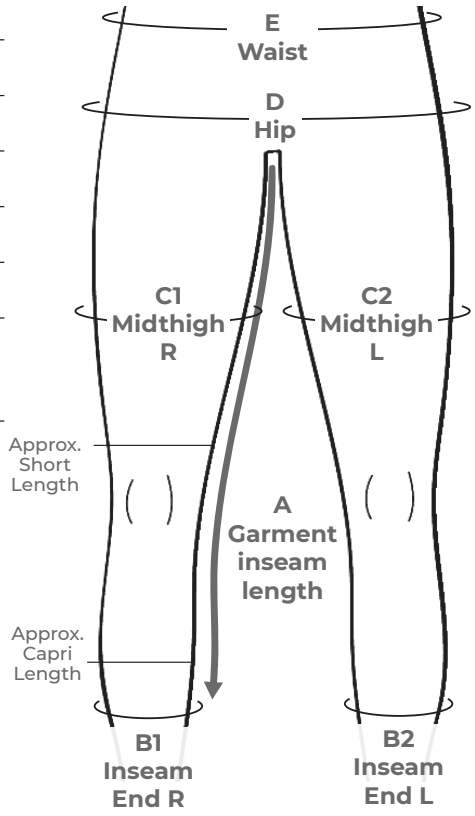
C1 Midthigh R _____

B2 Inseam End L _____

B1 Inseam End R _____

Length

A Inseam Length _____



Product Information

Custom Compreshorts are ideal for patients outside of the standard size range. Product includes one Compreshort Custom.

☐ Short Length

Color: Black Quantity:

☐ Capri Length

Color: Black Quantity:

Caution:

Elastic Band in sizes 2XL and larger contains natural rubber latex which may cause allergic reactions.

Note:

Ready to wear sizes are available in short and capri length.

Important

Exact measurements are critical for this garment to ensure a proper fit. If you have questions about measuring for this garment or would like assistance with measuring and fitting this garment please contact

Supplies needed

- Cell phone with camera. Photos of the arm with measurement markings must be emailed to:
- Measuring instructions and forms.
- SIGVARIS GROUP Measuring tape and body pen (or eyeliner pencil).

Measuring Instructions

Step 1:

Record the Circumference of the Waist, Hip, Midthigh Left, and Midthigh Right.

Step 2:

Measure from the groin down and indicate the garment inseam length.

Step 3:

Indicate the circumference of the Inseam end point and record circumferences.
For shorts, measure the Inseam and circumferences above the knee at the desired length.
For capris, measure the Inseam and circumferences below the knee at the desired length.

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Legassist®
CUSTOM CALF & FOOT

Patient Name:	Contact Name:	Height:	Weight:	Date:
Ship Name & Address:	Account Name:	Account #:	P.O #: :	

Product Information

Product includes one Legassist Calf and One Compreboot Plus Foot.

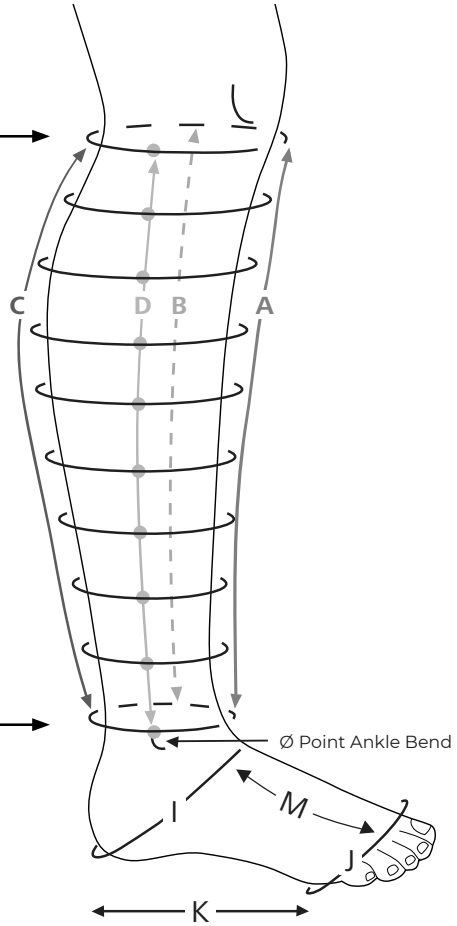
☐ Right Leg Size: ☐ Regular ☐ Super	☐ Left Leg Size: ☐ Regular ☐ Super	Foam ☐ Flat ☐ Wavefoam	Additional Foot Option ☐ Custom Medaboot (additional charge)
☐ Right Leg Size: ☐ Regular ☐ Super	☐ Left Leg Size: ☐ Regular ☐ Super	Foam ☐ Flat ☐ Wavefoam	Additional Foot Option ☐ Custom Medaboot (additional charge)

Note:
If the greatest circumference measurement is >60cm, order a Super.

Circumference Measurements
(Lateral aspect of leg)

Top of Garment _____
40cm _____
35cm _____
30cm _____
25cm _____
20cm _____
15cm _____
10cm _____
5cm _____
Ø (Point Ankle Bend) _____

* Choose a zero point distance from floor



Length Measurements

Anterior
A _____

Medial
B _____

Posterior
C _____

Lateral
D _____

Foot Measurments
I _____
J _____
K _____
M _____

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Legassist®

CUSTOM CALF & FOOT WITH SHELF

Patient Name:	Contact Name:	Height:	Weight:	Date:
Ship Name & Address:	Account Name:	Account #:	P.O #: :	

Product Information

Product includes one Legassist Calf and One Compreboot Plus Foot.

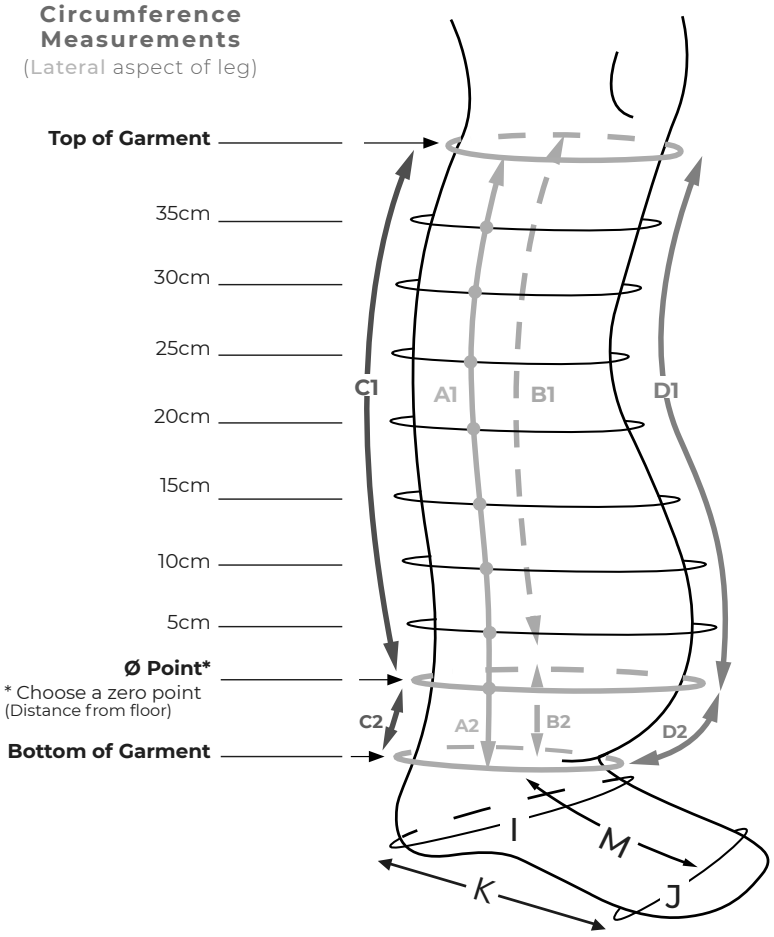
☐ Right Leg
☐ Left Leg

Foam
☐ Flat ☐ Wavefoam

Additional Foot Option
☐ Custom Medaboot (additional charge)

Note:
If the greatest circumference measurement is >60cm, order a Super.

Circumference Measurements
(Lateral aspect of leg)



Length Measurements

Lateral
A1 _____
A2 _____

Medial
B1 _____
B2 _____

Posterior
C1 _____
C2 _____

Anterior
D1 _____
D2 _____

Foot Measurments
I _____
J _____
K _____
M _____

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Legassist®

FULL LEG

Patient Name:	Contact Name:	Height:	Weight:	Date:
Ship Name & Address:	Account Name:	Account #:	P.O #: :	

Product Information

Product includes one Legassist Full Leg and one Compreboot Plus Foot.

☐ Right Leg Size: ☐ Regular ☐ Super ☐ Left Leg Size: ☐ Regular ☐ Super	Foam ☐ Flat ☐ Wavefoam	Additional Foot Option ☐ Custom Medaboot (additional charge)	Optional ☐ Hip Attachment
☐ Right Leg Size: ☐ Regular ☐ Super ☐ Left Leg Size: ☐ Regular ☐ Super	Foam ☐ Flat ☐ Wavefoam	Additional Foot Option ☐ Custom Medaboot (additional charge)	Optional ☐ Hip Attachment

Note:

If the greatest circumference measurement is >90cm, order a Super.

Circumference Measurements

● = Locations measured along Lateral aspect of leg

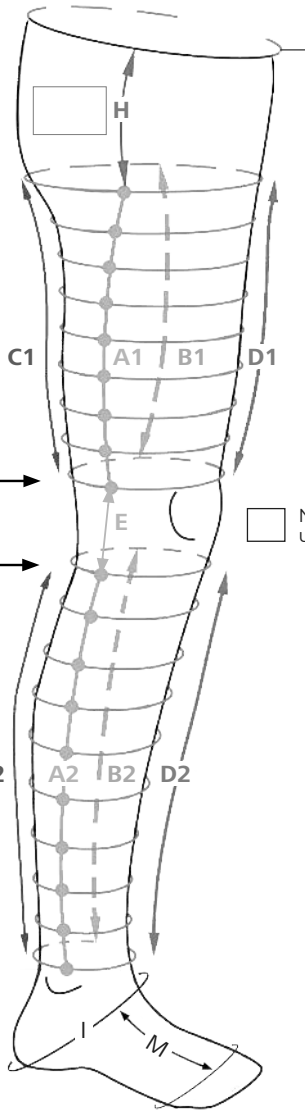
Top of Garment _____

35cm _____
30cm _____
25cm _____
20cm _____
15cm _____
10cm _____
5cm _____

Ø Point _____
Mid Patella _____
Ø Point _____

5cm _____
10cm _____
15cm _____
20cm _____
25cm _____
30cm _____
35cm _____
40cm _____

Ankle Bend _____



☐ **G:** Waist at bottom of belt

Ø Top of Patella

Ø Bottom of Patella

☐ No straps provided over knee unless box is checked

Length Measurements

Lateral

A1 _____
A2 _____

Medial

B1 _____
B2 _____

Posterior

C1 _____
C2 _____

Anterior

D1 _____
D2 _____

Knee

E _____

Foot Measurments

I _____
J _____
K _____
M _____

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Medaboot® Custom

FOOT

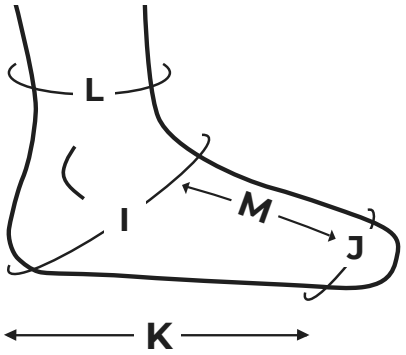
Patient Name:	Contact Name:
Account Name:	Account #:
Account Phone #:	P.O. #:
Height:	Weight:
Ship Name & Address:	Date:

Circumference

	Left	Right
I		
J		
L		

Length

	Left	Right
K		
M		



K Length: Measure **medial** length from heel to 1st metatarsal head

Product Information

Product includes one Medaboot.

☐ Right Foot	Color: Black	Quantity:
☐ Left Foot	Color: Black	Quantity:

Important

Exact measurements are critical for this garment to ensure a proper fit. If you have questions about measuring for this garment or would like assistance with measuring and fitting this garment please contact

Supplies needed

- Cell phone with camera. Photos of the arm with measurement markings must be emailed to:
- Measuring instructions and forms.
- SIGVARIS GROUP Measuring tape and body pen (or eyeliner pencil).

Measuring Instructions

All measurements should be recorded in centimeters. Apply slight tension to hold the tape measure in place.

Measure Foot

- Measure foot medially from heel to 1st metatarsal head (or desired boot length) and record length on line K.
- Measure top of foot from the 3rd metatarsal head to ankle bend and record length on line M.
- Encircle the ankle bend and heel with a tape measure and record the circumference on line I.
- Encircle the foot across the metatarsal heads and record the circumference on line J.
- Measure the ankle circumference and record on line L.

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SIGVARIS GROUP

Sigvaris Custom Flat Knit Order form
LOWER BODY **OPTIFORM® HOLD & FLEX**

☐ Order ☐ Multi-component garment ☐ Cost-estimate

Customer name _____

Customer number _____ Fitter _____

Patient name _____ _____

☐ female ☐ male

Order no. _____ Order date _____

Stamp / Signature / Ship to address:

SIGVARIS, INC.
1119 Highway 74 South
Peachtree City, GA 30269

Save Print Reset

Compression	**OPTIFORM**		**Quantity** (in units)			**Colors**		**Model**	
	Hold	Flex	Right	Left	Bodypart	☐ Beige	☐ Black Raspberry	☐ AB_1 Sock	☐ AT Pantyhose
CCL 1	☐	☐	____	____	____	☐ Black	☐ Deep Blue	☐ AD Calf	☐ AT Single-leg panty
CCL 2	☐	☐	____	____	____		☐ Mystic Green	☐ AG Thigh	☐ Bermuda _____
CCL 3	☐	■	____	____	____		☐ Stormy Gray	☐ Sleeve	☐ Capri _____
CCL 4	☐	■	____	____	____		☐ Mahogany Brown	_____	☐ BT Leggings
without compression	☐	☐	■	■	____				

Top Leg (AD – AG)

- ☐ Optiline
- ☐ 5 cm Knobbed grip top
- ☐ 3,5 cm Knobbed grip top
- ☐ Elasticated band (AD)
- ☐ Waist attachment (AG)
- ☐ Straight
- ☐ Shallow slant
- ☐ Steep slant
- ☐ Front leg elevation (AG)

Porous end ☐ top ☐ bottom
(3 – 8 cm) _____ cm

Top Waist

- ☐ Softline
- ☐ Elastic waistband
  - ☐ with velcro
- ☐ Elasticated band
  - ☐ with velcro
- ☐ Adjustable band
- ☐ Knobbed grip top 5cm

Gusset

- ☐ Standard
- ☐ Reinforced
- ☐ Open
- ☐ Mesh
- ☐ Fly opening

Heel options

- ☐ Standard
- ☐ T-heel
- ☐ Anatomical*

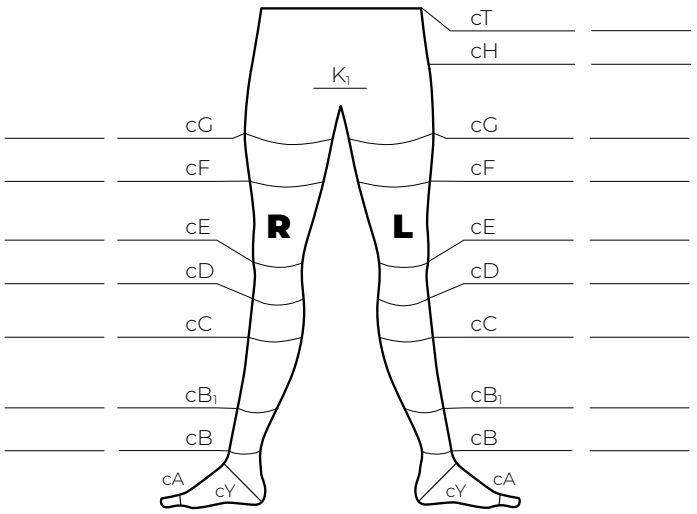
Functional zones

- ☐ Knee right
- ☐ Knee left
- ☐ Hallux valgus right
- ☐ Hallux valgus left
- ☐ Tailor's bunion right
- ☐ Tailor's bunion left

Measurement Leg: Circumference (= c)

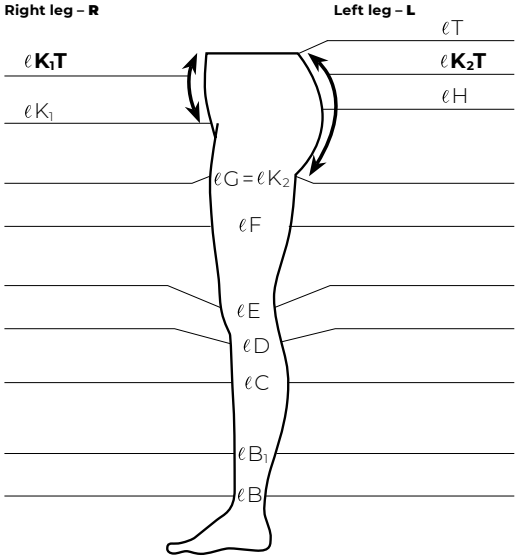
Right leg – R Skin Tensile

Left leg – L Tensile Skin



Measurement Leg: Length (= ℓ)

Right leg – R **Left leg – L**



Foot Circumference

R cA _____ cm cY _____ cm **L** cA _____ cm cY _____ cm

Foot Length

R ℓZ _____ cm (total) ℓA _____ cm (outside) ℓAi _____ cm (inside)

L ℓZ _____ cm (total) ℓA _____ cm (outside) ℓAi _____ cm (inside)

Additions / Options

- ☐ Silicone strip
- ☐ Lining
- ☐ Ankle pad
- ☐ Pocket
- ☐ Pocket with lymphpad
  - ☐ Wave ☐ Honeycomb small ☐ Honeycomb large
- ☐ Zipper

Label inside (Standard)
☐ Label outside

Please indicate/mark exact position and dimensions on the sheet «Additions to Sigvaris Flat knit garments»

Toe tip

- ☐ Closed
- ☐ Open
- ☐ Straight
- ☐ Slant
- ☐ Lower foot extension
- ☐ Standard
- ☐ Soft

Reinforced seam

- ☐ No design
- ☐ Design: color black
- ☐ Design: color beige
- ☐ Personalized (note text under «Remarks» , capital letters only, max. 40 characters)

Remarks

***** Please indicate / draw the exact position and measurements on the sheet «Additions to Sigvaris flat knit compression garments».

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POD / 07.2024 / V1 / 358560_USA_en

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SIGVARIS GROUP

Sigvaris Custom Flat Knit Additional / modification form
LOWER BODY **OPTIFORM HOLD & FLEX**

☐ Order ☐ Multi-component garment ☐ Cost-estimate

Customer name _____

Customer number _____ Fitter _____

Patient name _____ _____

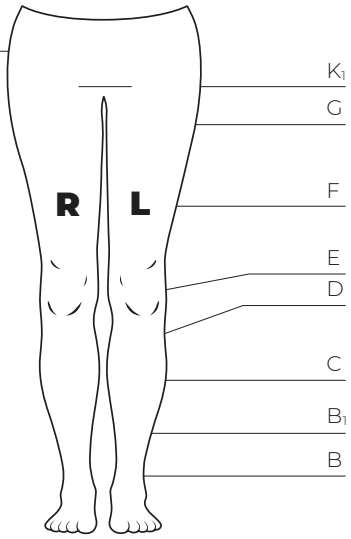
☐ female ☐ male

Order no. _____ Order date _____

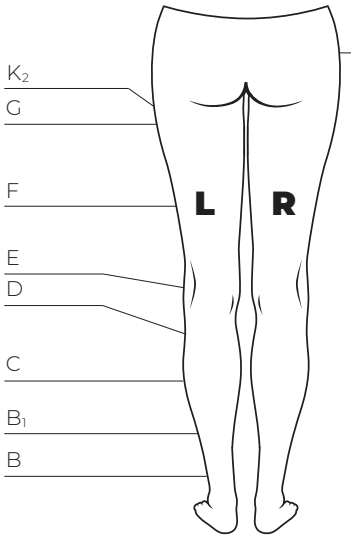
Stamp / Signature / Ship to address:

SIGVARIS, INC.
1119 Highway 74 South
Peachtree City, GA 30269

Front view

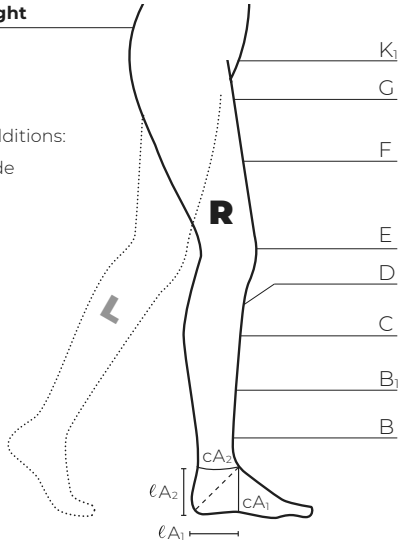


Back view



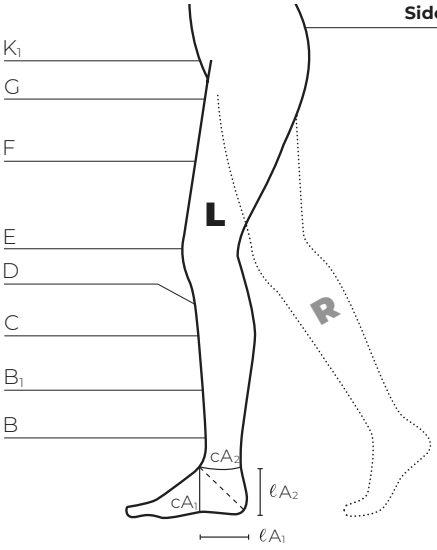
Side view, right

Position of additions:
—— = Outside
····· = Inside



cA1 _____ cm ℓA1 _____ cm
cA2 _____ cm ℓA2 _____ cm

Side view, left



cA1 _____ cm ℓA1 _____ cm
cA2 _____ cm ℓA2 _____ cm

Silicone strip(s) ☐ 3,5 cm ☐ 5 cm

R Right	**L** Left		
☐	☐	_____ cm	Silicone strip along slant
☐	☐	_____ cm	Silicone strip above knee
☐	☐	_____ cm	Silicone strip in back on seam
☐	☐	_____ cm	Silicone strip according to drawing

Zipper

☐ Leg – number: _____
☐ centered ☐ laterally inside
centered ☐ laterally outside

☐ Body bandage – number: _____
☐ centered ☐ laterally right
centered ☐ laterally left

☐ Hook-eye band

Sewn-in ankle pad

R Right
Inside:
P1: _____ cm
P2: _____ cm
Outside:
P1: _____ cm
P2: _____ cm

L Left
Inside:
P1: _____ cm
P2: _____ cm
Outside:
P1: _____ cm
P2: _____ cm

Pocket / Lining

☐ Pocket for pad – number: _____
☐ **R** Right ☐ **L** Left
Width _____ cm
Length _____ cm

☐ Lining – number: _____
☐ **R** Right ☐ **L** Left
Width _____ cm
Length _____ cm

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POD / 12.2024 / V1 / 358561_USA_en

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SIGVARIS GROUP

Sigvaris Custom Flat Knit Order form
LOWER BODY **OPTIFORM® TOE CAPS**

☐ Order ☐ Multi-component garment ☐ Cost-estimate

Customer name _____

Customer number _____ Fitter _____

Patient name _____

Order no. _____ Order date _____

Stamp / Signature / Ship to address:

SIGVARIS, INC.
1119 Highway 74 South
Peachtree City, GA 30269

Save Print Reset

Compression	**OPTIFORM** Toe Caps	**Quantity** (in pieces) Right	Left
CCL 1	☐	____	____
CCL 2	☐	____	____

Colors
☐ Beige ☐ Black Raspberry
☐ Black ☐ Deep Blue
☐ Mystic Green
☐ Stormy Gray
☐ Mahogany Brown

Toe cap AA1
Open toes
☐ with little toe
☐ without little toe, (circumference and length also needed for little toe)

Ending
☐ Standard
☐ Porous

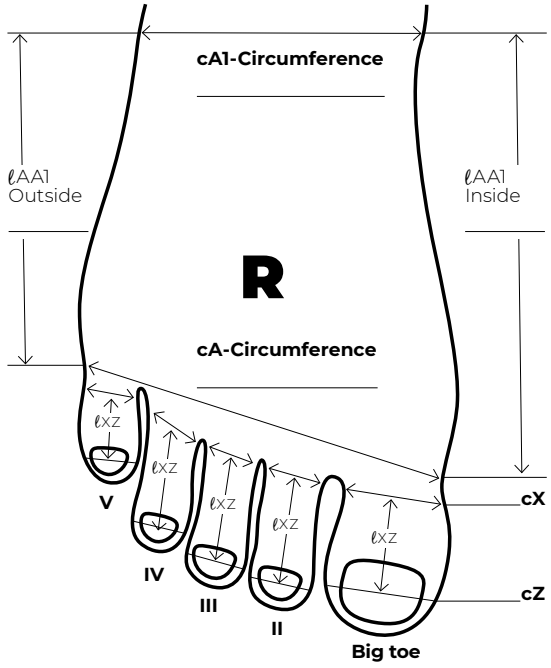
Additions/Options
☐ Liner** Width ____ cm Length ____ cm
☐ Pocket** Width ____ cm Length ____ cm

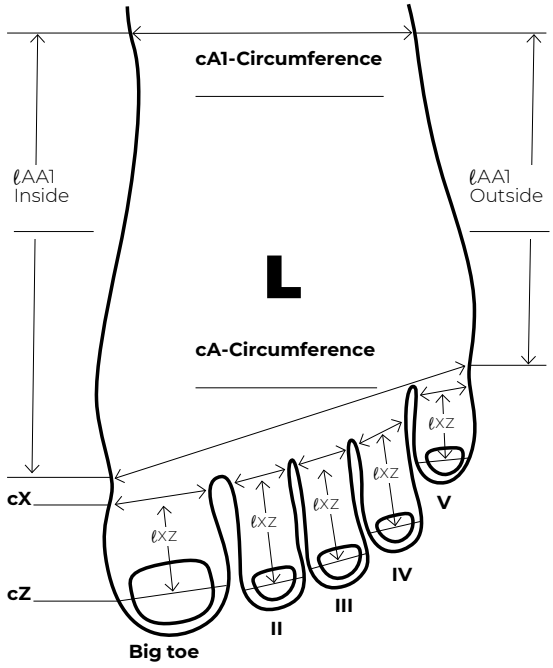
Label inside (Standard)
☐ Outside

Attention: Toe length measurement from the base of the webbed skin (X) to the desired end (Z), usually nail base or middle of the nail

Right	Circumference X	Circumference Z	Length ℓX-Z
Big toe			
Toe II			
Toe III			
Toe IV			
Toe V			

Left	Circumference X	Circumference Z	Length ℓX-Z
Big toe			
Toe II			
Toe III			
Toe IV			
Toe V			





Remarks

**Please indicate/draw exact position and dimensions on order sheet.
Liner and pocket max. 3/4 of circumference.

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SC / X'000 / 05.2024 / V1 / 358559_USA_en

SIGVARIS GROUP

Sigvaris flat knit compression garments
UPPER BODY **OPTIFORM® FEEL**

☐ Order ☐ Multi-component garment ☐ Cost-estimate

Customer name _____

Customer number _____ Fitter _____

Patient name _____

Order no. _____ Order date _____

Stamp / Signature / Ship to address:

SIGVARIS, INC.
1119 Highway 74 South
Peachtree City, GA 30269

Save Print Reset

Compression	OPTIFORM FEEL
CCL 1	☐
CCL 2	☐
CCL 3	☐

Colors
☐ Light beige ☐ Black Raspberry
☐ Beige ☐ Deep Blue
☐ Black ☐ Mystic Green
☐ Stormy Gray
☐ Mahogany Brown

Model
☐ Fingerling (only CCL 1)
☐ AC1 Glove / Mitten
☐ AE Glove to elbow
☐ AG Sleeve with glove / mitten*
☐ CE Sleeve to elbow
☐ CG Armsleeve

Hand piece (AC1, AE, AG)
☐ Mitten, without fingers, with thumb
☐ Length 1,5 cm (Standard)
☐ Individual length _____ cm
☐ With fingers and thumb
☐ Closed fingers
☐ Open fingers

Arm CE, CG

Distal ending
☐ Straight
☐ Porous (incl. Optiline)
☐ 3 cm (Standard)
☐ 6 cm

Arm AE, AG, CE, CG

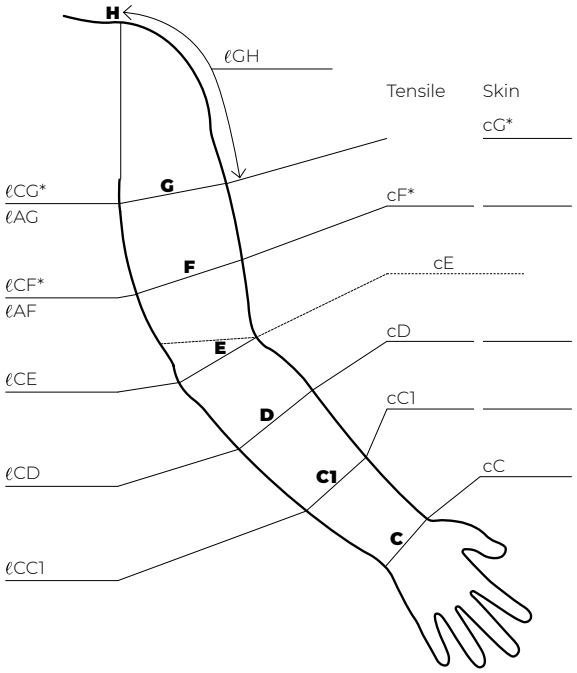
Proximal ending
☐ Optiline
Knobbed grip top
☐ 3,5 cm
☐ 5 cm
☐ 3/4 inside (3,5 cm only with measuring point G)
☐ Shallow slant
☐ Steep slant (only with measuring point G)
☐ Straight
☐ Porous (incl. Optiline)
☐ 3 cm (Standard)
☐ 6 cm

Elbow
☐ Angle 160° (Standard)
☐ Angle 150°
☐ Angle 135°
☐ Elbow functional zone

Ending AC1 Glove
☐ Slant
☐ Straight
☐ Porous (incl. Optiline)
☐ 3 cm (Standard)
☐ 6 cm

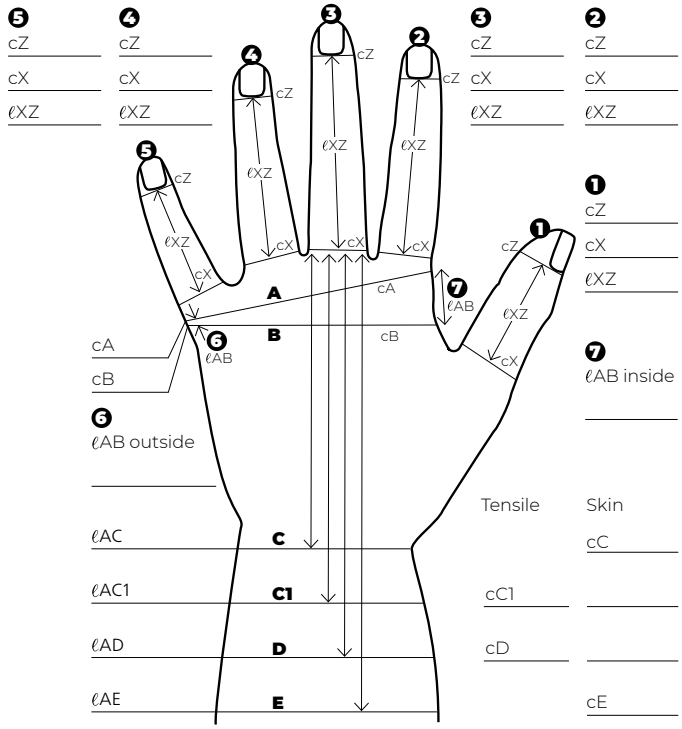
Arm ☐ left ☐ right Quantity _____

Circumference measuring (c = circumference) and length measuring (ℓ = length) in cm
Important: Arm length measuring starts at C
*For AG Sleeve with glove/mitten, please indicate the length ℓAF, ℓAG and the circumference cF, cG on the arm section below



Hand ☐ left ☐ right Quantity _____

Circumference measuring (c = circumference) and length measuring (ℓ = length) in cm
Important: Length for models with glove start at base of middle finger



Additions / Options

☐ Shoulderstrap
_____ cm
☐ Bra attachment
Bolero
☐ single piece ☐ two-piece
_____ cm (ℓHH)
_____ cm Back width

☐ Attachment Fingerling*
☐ Zipper**
☐ Hook-eye band
Label inside (Standard)
☐ Outside
☐ Seam inside (CE and CG)

☐ Liner**
Width _____ cm
Length _____ cm
☐ Silicone strip**
☐ 3,5 cm
☐ 5 cm
Length _____ cm

☐ Pocket**
Width _____ cm
Length _____ cm
with lymphpad
☐ Wave
☐ Honeycomb small
☐ Honeycomb large

Comments

*Please specify cC and ℓAC **Please indicate / draw exact position and dimensions on order sheet. Liner, pocket and silicone strips max. 3/4 of circumference.

Delivery time: up to 10 working days

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THUASNE

MOBIDERM

☐ Order
☐ Quotation
☐ Renewal

Patient's First Name: _____

Patient's Last Name: _____

Gender: ☐ M ☐ F ☐ Pediatric

Patient Height: _____

Case No. for renewal: _____

☐ 1st Treatment

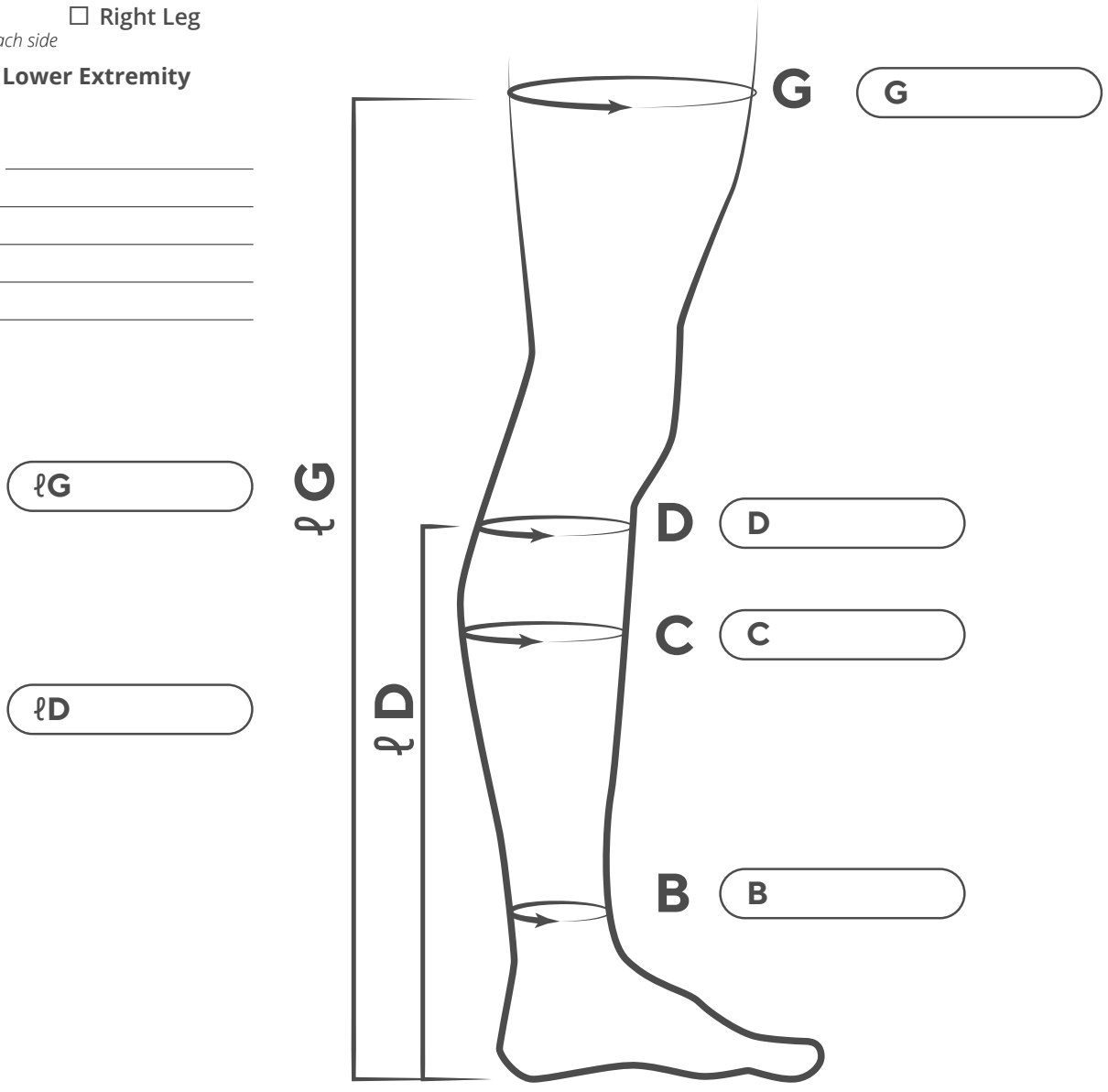
Date: _____ **Quantity:** _____

☐ Left Leg ☐ Right Leg
Fill out one for each side

MOBIDERM Lower Extremity

☐ Auto Fit

Comments: _____



MOBIDERM

THUASNE

☐ Order
☐ Quotation
☐ Renewal

Patient's First Name: _____

Patient's Last Name: _____

Gender: ☐ M ☐ F ☐ Pediatric

Patient Height: _____

Case No. for renewal: _____

☐ 1st Treatment

Date: _____ **Quantity:** _____

☐ Left Arm ☐ Right Arm
Fill out one for each side

MOBIDERM autofit

Comments: _____

**Note: We recommend going up one size to accommodate for upper arm coverage*

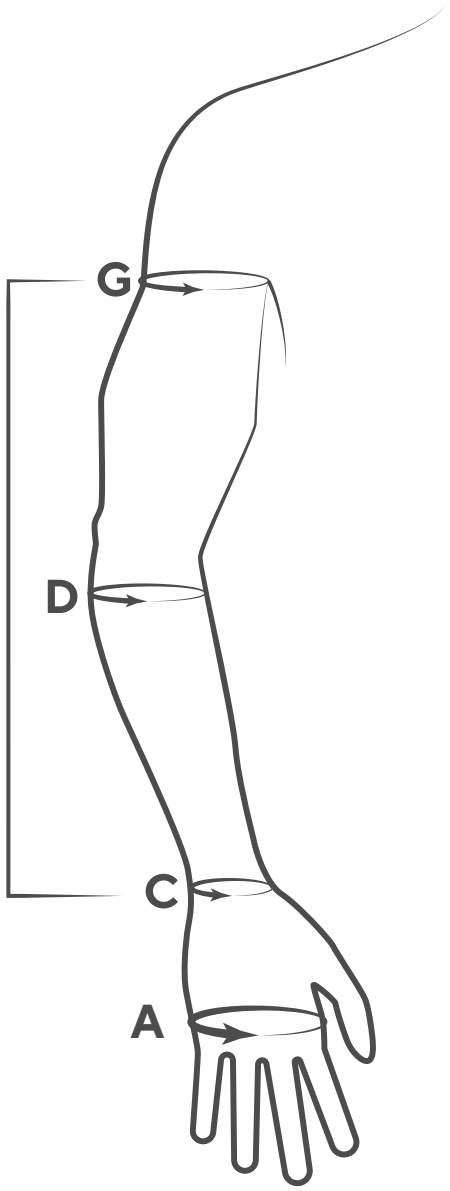
G

D

ℓ

C

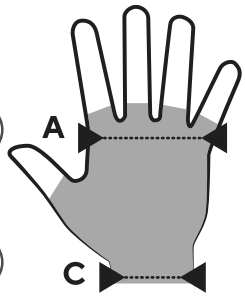
A



Mitten

A

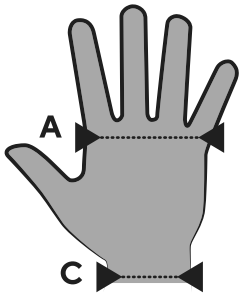
C



Glove

A

C



☐ Left Hand ☐ Right Hand
Fill out one for each side

MOBIDERM

☐ Mitten ☐ Glove

Comments: _____

Comfort Care Medical

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Questions? **888.358.1580**

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THUASNE

MOBIDERM

MADE-TO-MEASURE
LOWER EXTREMITY GARMENT

Patient Name: .....

Gender : ☐ M ☐ F .....

Patient's height: .....

☐ **ORDER** *(by default)* ☐ **QUOTATION** ☐ **REORDER**

Please complete and submit to Knit-Rite/Thuasne customer service.

Customer Name: .....

Customer Account: .....

Purchase Order #: ..... **Ships To:** ☐ Therapist ☐ Patient

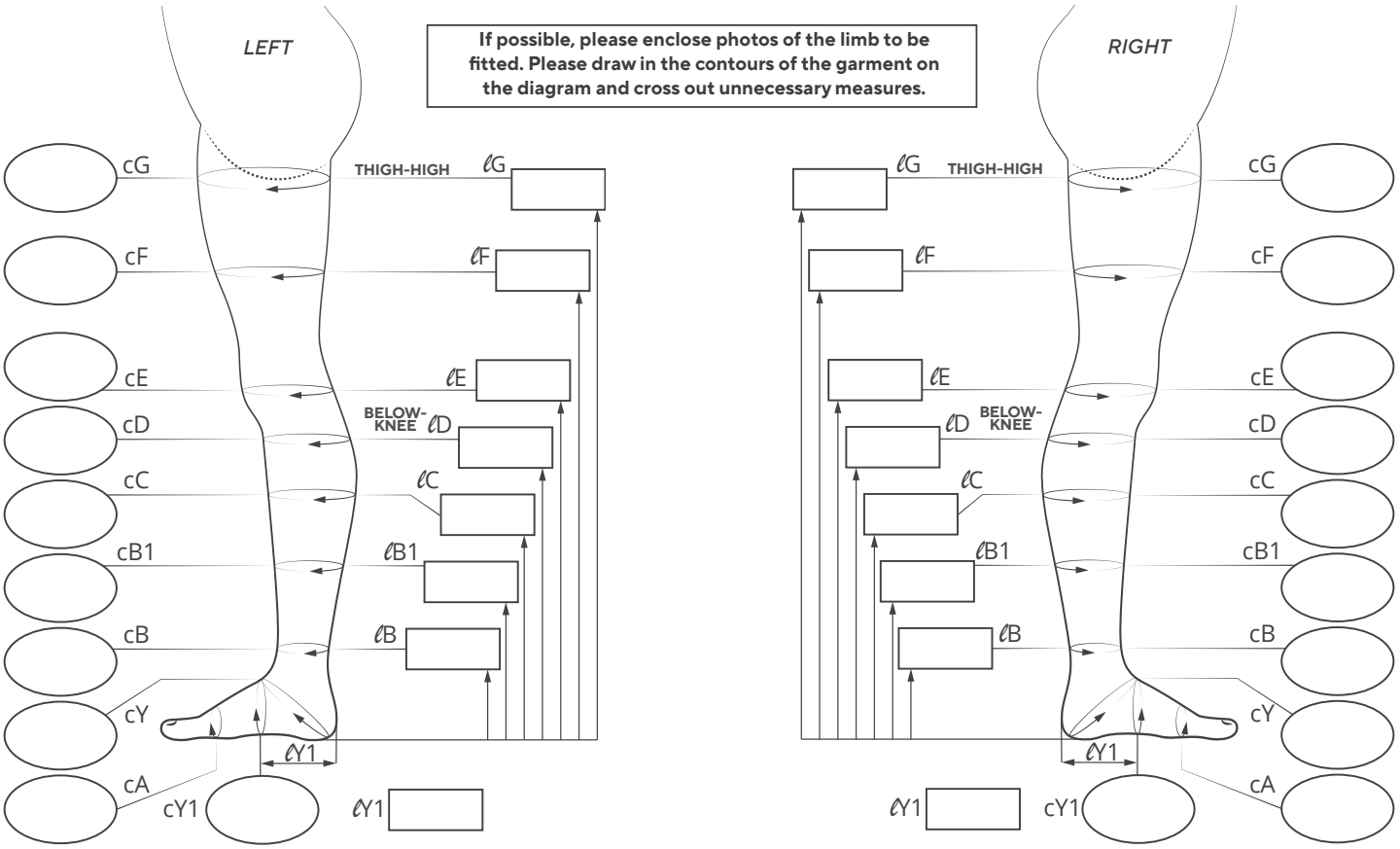
Shipping Address: .....

City: ..... **State:** ..... **Zip Code:** .....

Email: .....

Phone: .....

If possible, please enclose photos of the limb to be fitted. Please draw in the contours of the garment on the diagram and cross out unnecessary measures.



Desired foot length:

Inner (ℓA)	
Outer (ℓA1)	

Desired foot length:

Inner (ℓA)	
Outer (ℓA1)	

Models

	LEFT	RIGHT
☐ Below-knee	☐	☐
☐ Thigh-high	☐	☐

Foam options
☐ All small blocks
☐ All big blocks
☐ Big blocks on the leg and small blocks on the feet *(by default)*

Proximal options
☐ Anti-slip with silicone dots 3 cm
☐ Velcro opening *(Maximum 1/3 of the height)*

Distal options
☐ Open toe
☐ Closed toe

Special Instructions

.....

.....

.....

.....

▭ Length in cm
◯ Circumference in cm

INTERNAL USE ONLY
Customer Code: 67855

THERAFIRM®
THUASNE

THUASNE

MOBIDERM

MADE-TO-MEASURE
UPPER EXTREMITY SLEEVE

Please complete and submit to Knit-Rite/Thuasne customer service.

Patient Name: .....

Gender : ☐ M ☐ F .....

Patient's height: .....

☐ **ORDER** *(by default)* ☐ **QUOTATION** ☐ **REORDER**

Customer Name: .....

Customer Account: .....

Purchase Order #: ..... **Ships To:** ☐ Therapist ☐ Patient

Shipping Address: .....

City: ..... **State:** ..... **Zip Code:** .....

Email: .....

Phone: .....

☐ **RIGHT ARM** ☐ **LEFT ARM**
Fill out one form for each side

If possible, please enclose photos of the limb to be fitted. Please draw in the contours of the garment on the diagram and cross out unnecessary measures.

Models
☐ Arm Sleeve *(big blocks only)*
☐ Arm Sleeve with mitten with thumb
(big blocks on the arm and small blocks on the hand)
☐ Arm Sleeve with mitten without thumb
(big blocks on the arm and small blocks on the hand)

Sleeve options
☐ Anti-slip with silicone dots 3cm
☐ Velcro opening
Please draw desired location on the diagram and indicate desired length in the special instructions area below.

Special Instructions
Please draw the desired rise at the shoulder on the diagram and indicate the length from the top of cG to the shoulder (maximum 4cm).

.....

.....

.....

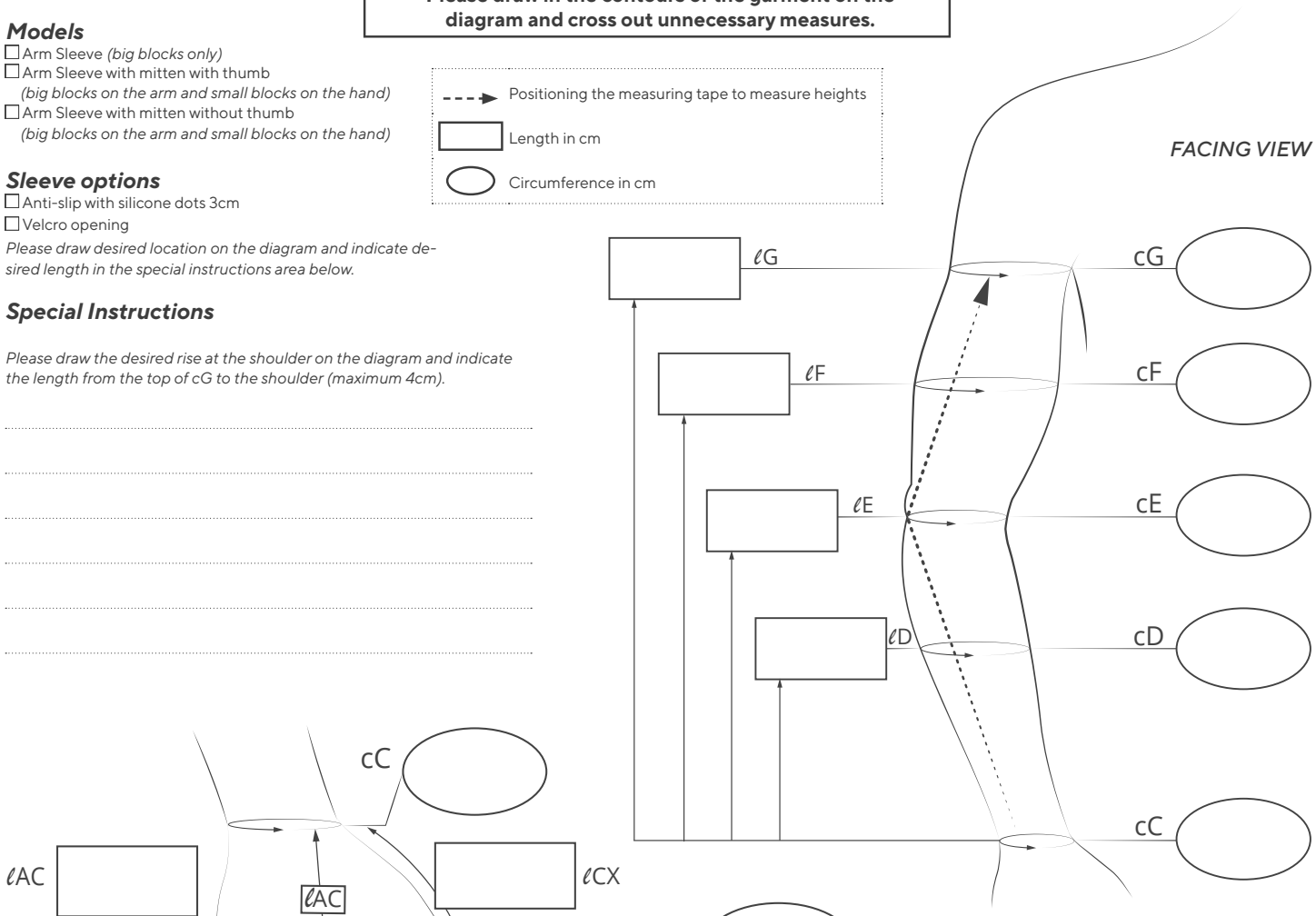
.....

.....

.....

Positioning the measuring tape to measure heights
Length in cm
Circumference in cm

FACING VIEW



INTERNAL USE ONLY
Customer Code: 67855

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Include demographics, insurance card, evaluation and the order form

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