PURE MEDICAL
OUR COMMITMENT. YOUR COMFORT.

Pure Day Upper Extremity Order Form

PATIENT INFORMATION

Name: _____ Phone Number: _____ Order Date: _____

Therapist /Fitter: Name: _____ Phone Number: _____

Email: _____ Reorder of Order #: _____ Measurement Date: _____

GARMENT

Style PD - UE - _____

☐ Left Arm ☐ Right Arm

☐ Thumb Slit ☐ Full Thumb C= _____

Compression

☐ 20-30 mmHg ☐ 30-40 mmHg

☐ Other _____

Modifications

Placement Instruction

☐ No Silicone ☐ 1/2 Silicone ☐ Silicone

☐ Zippers _____

BILLING INFORMATION ☐ Quote Only

Business Name: _____

Phone: _____ Fax: _____

Contact Name: _____

Account #: _____ P.O. #: _____

Payment:

☐ Credit card ☐ Net 30

Card #: _____

Exp: _____ SID: _____

SHIPPING INFORMATION

Shipping:

Requested Delivery Date: _____

☐ Standard ☐ Priority

Ship to: _____

Attn: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____

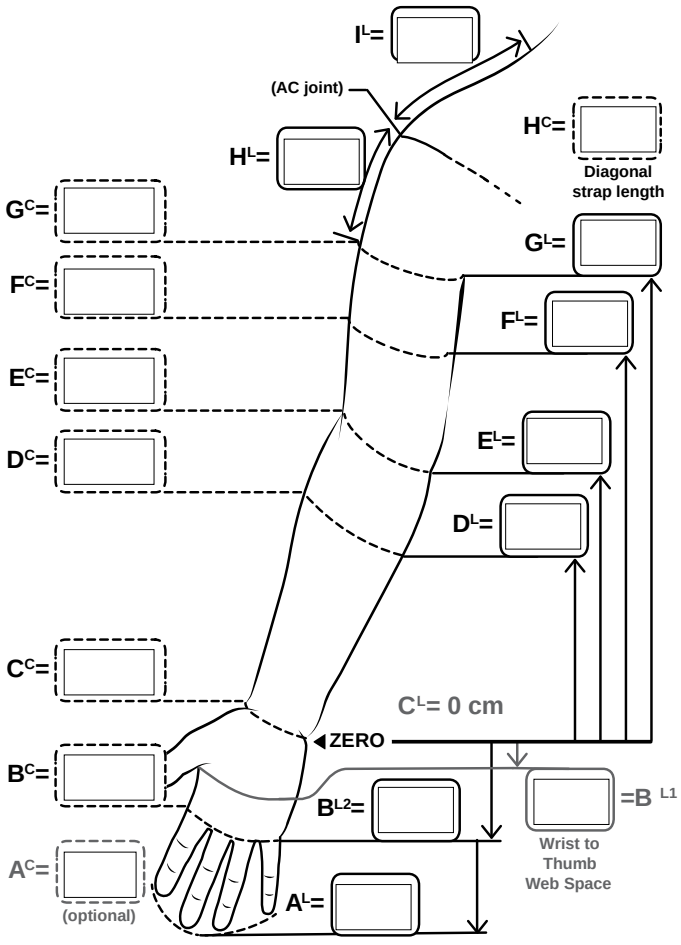
Email: _____

(for shipping notification)

MEASUREMENTS

(All measurements in centimeters)

C = Circumference L = Length



Notes:

V 2024.01