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

STANDARD WRITTEN ORDER : BANDAGING FORM

(SECTION 1) GENERAL INTAKE INFORMATION

Comfort Care Medical
PHONE: (888) 358-1580
FAX: (443) 455-1402
WWW.COMFORTCAREMD.COM

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 ALONGSIDE THIS PRESCRIPTION FORM ACKNOWLEDGING PATIENT DIAGNOSIS INDICATED 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

CHECK SIZE AND WRITE QUANTITY FOR EACH ITEM ORDERED · QUANTITY (QTY) MUST BE INCLUDED IN THE MEDICAL RECORD*

A. STOCKINETTE & TUBULAR		
POLYSOFT STOCKINETTE	☐ 2in×25yd ☐ 3in×25yd ☐ 4in×25yd ☐ 6in×25yd ☐ 8in×25yd	QTY:
TRICOFIX TUBULAR	☐ 6cm×20m ☐ 8cm×20m ☐ 10cm×20m ☐ 12cm×20m	QTY:
TG TUBULAR	☐ SIZE 6 ☐ SIZE 7 ☐ SIZE 9 ☐ SIZE 12 ☐ K1 ☐ K2	QTY:
TG GRIP TUBULAR SUPPORT	☐ A 4.6cm×10m ☐ D 7.5cm×10m ☐ G 12cm×10m	QTY:
TG SOFT TUBULAR PADDING	☐ S ☐ M ☐ L	QTY:
B. PADDING & FOAM		
ARTIFLEX PADDING	☐ 10cm×3m ☐ 15cm×3m	QTY:
CELLONA UNDERCAST PADDING	☐ 6cm×3m ☐ 10cm×3m ☐ 15cm×3m	QTY:
KOMPREX FOAM PAD	☐ SIZE 00 ☐ SIZE 0 ☐ SIZE 1 (12cm×1.2cm)	QTY:
KOMPREX FOAM SHEET	☐ 50cm×1m×1cm	QTY:
ROSIDAL SOFT FOAM	☐ 10cm×2.5m ☐ 12cm×2.5m ☐ 15cm×2.5m	QTY:
SIGVARIS GRAYFOAM	☐ 1/4in ☐ 1/2in	QTY:
COMPRIFOAM	☐ 10cm×2.5m ☐ 12cm×2.5m	QTY:
C. CONFORMING / GAUZE		
MOLLELAST CONFORMING	☐ 4cm×4m ☐ 6cm×4m ☐ 10cm×4m	QTY:
TRANSELAST CLASSIC CONFORMING	☐ 4cm×4m ☐ 6cm×4m	QTY:
ELASTOMULL GAUZE (NON-STERILE)	☐ 1in×4.4yd ☐ 2in×4.4yd ☐ 3in×4.4yd	QTY:
D. SHORT-STRETCH COMPRESSION (SIZES SHOWN AS cm × m)		
ROSIDAL K	☐ 4×5 ☐ 6×5 ☐ 8×5 ☐ 10×5 ☐ 10×10 ☐ 12×5 ☐ 12×10	QTY:
COMPRILAN	☐ 4×5 ☐ 6×5 ☐ 8×5 ☐ 10×5 ☐ 10×10 ☐ 12×5 ☐ 12×10	QTY:
E. ELASTIC / ALL-PURPOSE		
IDEALBINDE	☐ 15cm×5m LENKELAST ☐ 8cm×5m ☐ 10cm×5m ☐ 12cm×5m ☐ 15cm×5m ☐ 20cm×5m	QTY:
F. FINISHING & TAPE		
ISOBAND FINISHED EDGE	☐ 6in×5yd ☐ 8in×5yd	QTY:
SILKAFIX ADHESIVE TAPE	☐ 2.5cm×5m (12pk) ☐ 5cm×5m (6pk)	QTY:
G. SPECIALTY		
	☐ DAUERBIND K LONG-STRETCH 8cm×7m ☐ GELOCAST UNNA BOOT 3in×10yd	QTY:
H. POST-OP FOOTWEAR (DARCO SURGICAL SHOE, BLACK)		
	MEN'S: ☐ S ☐ M ☐ L ☐ XL WOMEN'S: ☐ S ☐ M ☐ L	QTY:
I. OTHER / WRITE-IN (ITEMS NOT LISTED ABOVE)		
		QTY:
		QTY:

(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 EITHER 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'S NAME: _____ PHYSICIAN PHONE: _____

PHYSICIAN NPI: _____ PHYSICIAN FAX: _____

SIGNATURE: _____ DATE: _____