PLEASE FILL OUT EACH SECTION OF THE FORM · INCLUDE THE PATIENT'S DEMOGRAPHIC TO AVOID DELAYS

STANDARD WRITTEN ORDER: READY-TO-WEAR COMPRESSION 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) MEASUREMENTS AND 'READY TO WEAR' LYMPHEDEMA PRODUCTS

LOWER EXTREMITY MEASUREMENTS (cm)

ANKLE (CIRC.) _____ LT _____ RT
CALF (CIRC.) _____ LT _____ RT
LEN. (HEEL–KNEE) _____ LT _____ RT
THIGH (CIRC.) _____ LT _____ RT
LEN. (HEEL–BUTTOCKS) _____ LT _____ RT

UPPER EXTREMITY MEASUREMENTS (cm)

PALM (CIRC.) _____ LT _____ RT
WRIST (CIRC.) _____ LT _____ RT
ELBOW (CIRC.) _____ LT _____ RT
AXILLA (CIRC.) _____ LT _____ RT
LEN. (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	THIGH-HIGH	ARM/HAND
DAYTIME GARMENT	**DAYTIME GARMENT**	**DAYTIME GARMENT**
_____ ☐ LT ☐ RT ___QTY	_____ ☐ LT ☐ RT ___QTY	_____ ☐ LT ☐ RT ___QTY
_____ ☐ LT ☐ RT ___QTY	_____ ☐ LT ☐ RT ___QTY	_____ ☐ LT ☐ RT ___QTY
_____ ☐ LT ☐ RT ___QTY	_____ ☐ LT ☐ RT ___QTY	_____ ☐ LT ☐ RT ___QTY
NIGHTTIME GARMENT	**NIGHTTIME GARMENT**	**NIGHTTIME GARMENT**
_____ ☐ LT ☐ RT ___QTY	_____ ☐ LT ☐ RT ___QTY	_____ ☐ LT ☐ RT ___QTY
_____ ☐ LT ☐ RT ___QTY	_____ ☐ LT ☐ RT ___QTY	_____ ☐ LT ☐ RT ___QTY
COMPRESSION LEVEL	**COMPRESSION LEVEL**	**COMPRESSION LEVEL**
18-30 mmHg ☐ LT ☐ RT	18-30 mmHg ☐ LT ☐ RT	18-30 mmHg ☐ LT ☐ RT
30-40 mmHg ☐ LT ☐ RT	30-40 mmHg ☐ LT ☐ RT	30-40 mmHg ☐ LT ☐ RT
>40 mmHg ☐ LT ☐ RT	>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 EITHER 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

PHYSICIAN'S NAME: _____ PHYSICIAN PHONE: _____

PHYSICIAN NPI: _____ PHYSICIAN FAX: _____

SIGNATURE: _____ DATE: _____