Compression Garment Order Form

Patient Name:______________________ **Date of Birth:**_________________

Check one: **Compreflex** **Juxtalite**

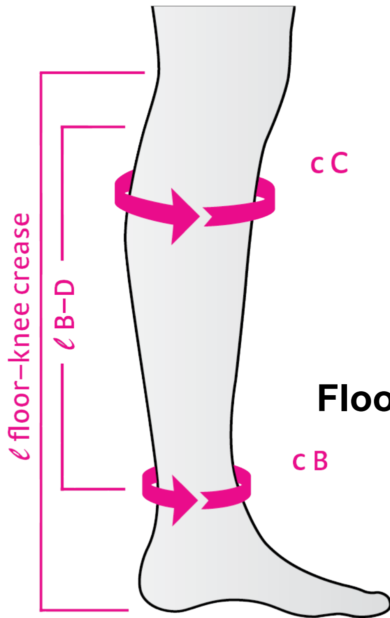
Insurance Criteria:

***Medicare*- Patient must have a Venous Stasis Ulcer and not be in a Home Health episode**

***Private Insurance(including Medicare HMO)*- Patient only needs edema documented**

***Self Pay*= $75 per garment**

Please take measurements seen on diagram



Measurements:

	Left	Right
B:	______________cm	______________cm
C:	______________cm	______________cm
B-D:	______________cm	______________cm
Floor to Knee:	______________cm	______________cm

Physician's signature:_________________________ **Date:**______________

Please fax order form, office notes and demographics to 866-573-4490