MEDICAL COMPRESSION ORDER

Patient Name: _____ **DOB:** _____

Address: _____ **Phone #:** _____

Insurance ID #: _____

Check all that apply:

18 - 30 mmHg

- □ Gradient Compression Stocking, **below knee**, each QTY: _____
- □ Gradient Compression Stocking, **thigh length**, each QTY: _____

30 - 40 mmHg

- □ Gradient Compression Stocking, **below knee**, each QTY: _____
- □ Gradient Compression Stocking, **thigh length**, each QTY: _____

20 - 50mmHg

- □ Gradient Compression Wrap, **below knee**, each QTY: _____

Ankle Circumference (inches): _____

Calf Circumference (inches): _____

Length Heel to Knee (inches): _____

DIAGNOSIS/ICD-10 CODE(S): _____

Prescriber Name: _____ **NPI:** _____

Office Address: _____ **Phone #:** _____

Prescriber Signature: _____ **Date:** _____

INLAND
DURABLE MEDICAL EQUIPMENT & MEDICAL SUPPLY

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