FAX :

PRESCRIPTION AND REFERRAL FOR PNEUMATIC COMPRESSION DEVICE AND/OR COMPRESSION GARMENTS

ELITE

COMPRESSION & BRACING

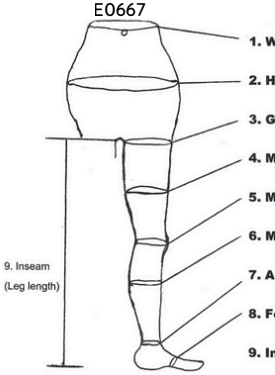
Referral from:
Patient Name:

Please include:

- Patient Demographic Sheet
- Insurance information (card front & back)
- Pneumatic Device E0651_____E0652_____

leg measurements to include:
3-7 and inseam

E0667



	Left	Right
1. Waist		
2. Hips		
3. Groin		
4. Mid Thigh		
5. Mid Knee		
6. Mid Calf		
7. Ankle		
8. Foot arch		
9. Inseam (Leg length)		

Inseam = Leg length (groin to bottom of heel for # 9)

E0668

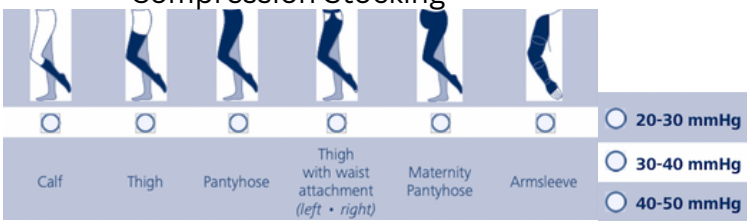
	Left	Right
1. Axilla (armpit)		
2. Mid Bicep		
3. Elbow		
4. Mid Forearm		
5. Wrist		
6. Hand (w/ thumb)		
7. Length of arm (Axilla to longest fingertip)		

8. _____ Upper Chest over breast

9. _____ Mid Chest

10. _____ Abdomen

Compression Stocking



Signature:_____ **Date:**_____

Notes:_____

_____

_____

Diagnosis_____._____Onset Date:_____ Measurement date_____

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TO ORDER PLEASE SECURELY FAX OR EMAIL