



510-350-9166 Fax
Standard Written Order

1329 Howe Ave Suite 101
Sacramento, CA. 95825 PH:
916-480-9501
NPI: 1245698984

Date: _____

Name: _____ DOB: _____

☐ Left ☐ Right ☐ Bilateral ☐ Pair

Compression Garments #of Refill x _____ Frequency _____

☐ Gauntlets x _____ ☐ Gloves x _____ ☐ Arm Sleeves x _____

☐ Knee Highs ☐ Thigh Highs ☐ Pantyhose ☐ Vest

☐ Custom ☐ Ready-Made

☐ 15-20mmHg ☐ 20-30mmHg ☐ 30-40mmHg ☐ 40-50mmHg

☐ Nighttime Lymphedema Garment - _____

☐ Lymphedema Compression Pad - _____

☐ Other _____

Additional Notes:

Referring Provider: _____

NPI: _____

Address: _____

Phone: _____ Fax: _____

Referring Provider's Signature

Date

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REFERRING PROVIDER, _____

Your patient has an appointment
with us on _____

1) Add diagnosis codes that support
need of supplies

2) Sign & date this order (signature
stamps not allowed by CMS)

3) Attach a recent progress note
supporting medical need &/or
continued use for requested
supplies incl. diagnosis, surgeries,
asymmetry, treatment plan.

Fax to 510-350-9166

DIAGNOSIS CODES:

☐ I89.00 ☐ _____

OTHER: _____