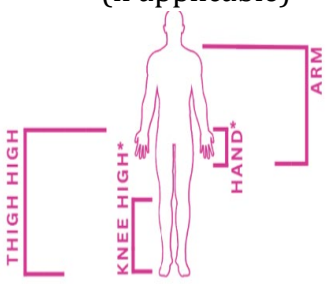
Send orders for compression garments, donning aides, and bandaging supplies to
Specialized Medical Solutions, fax 210-257-8474

Please include with order:

I. Patient Demographics Page
II. Standard Written Order (SWO)- Including;
  A. Patient Name & DOB
  B. Order Date
  C. Diagnosis Code(s)
  D. Item(s) for order, including
    1) Compression Level
    2) Effected limb
    3) Day and/or nighttime garments
    4) Quantity
    5) Include donning aide on the SWO, if applicable.
  E. Treating Practitioner Name, NPI, contact info, signature, and date.
  F. If ordering Bandaging Supplies these additional items are needed;
    1) Frequency of change for bandages (ex. 2X a week, 3X a week)
    2) Phase
      - Phase 1: Acute or decongestive therapy
      - Phase 2: Maintenance phase of therapy
III. Medical Records
  A. Chart notes from the prescribing practitioner, must include dx code on the SWO.
  B. Medical records from the lymphedema therapist are required, if under their care.

MEASUREMENTS: UPPER AND LOWER EXTREMITY
(if applicable)

Lower Extremity Measurements (CM)		
Lengths		
Heel to Knee	_____LT	_____RT
Heel to Glute Fold	_____LT	_____RT
Circumferences		
Ankle	_____LT	_____RT
Calf	_____LT	_____RT
Thigh	_____LT	_____RT



Upper Extremity Measurements (CM)		
Lengths		
Wrist to Axilla	_____LT	_____RT
Circumferences		
Palm	_____LT	_____RT
Wrist	_____LT	_____RT
Elbow	_____LT	_____RT
Axilla	_____LT	_____RT

Specialized Medical Solutions
7254 Blanco Rd. Ste. 208 • San Antonio, TX
205 Cheatham St., Suite 1 • San Marcos, TX
PH: (210) 236-9824 • FX: (210) 257-8474

STANDARD WRITTEN ORDER

Date: _____
Patient Name: _____ DOB: _____
Patient Address: _____ Phone: _____

☐ I89.0 Secondary Lymphedema
☐ 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

Length of Need: ☐ Lifetime (99) ☐ Other, please explain: _____

Compression Level (mmHg)
☐ 20-30 mmHg ☐ 30-40 mmHg ☐ 40+ mmHg ☐ Other: _____

Treatment Area:
☐ Left ☐ Right ☐ Bilateral

☐ Upper Extremity
☐ Arm ☐ Hand
Other: _____

☐ Lower Extremity
☐ Below Knee ☐ Thigh ☐ Waist
Other: _____

☐ Daytime Compression Garments Quantity (1-6): _____
☐ Nighttime Compression Garments Quantity (1-2): _____
☐ Bandaging Supplies Frequency of Change: _____
☐ Donning Aides
Notes:
_____
_____

I certify I am the treating provider identified below. The information found on this document of medical necessity and any information on any attached documents signed and dated by me, are true to the best of my knowledge. I certify the items prescribed above are medically necessary, are appropriate, need and replacement is ongoing, and can safely be used in the patient's home when used as prescribed.

Provider Name: _____ NPI: _____
Provider Address: _____
Provider Phone: _____ Provider Fax: _____
Signature: _____ Date: _____

SMS℠
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