Rehab Services, LLC
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Compression Stockings

Physician Order, Prescription and Certificate of Medical Necessity

Patient Name: _____ **Patient DOB:** _____

Patient Phone Number: _____ **Date of Order:** _____

Diagnosis Code: _____ **Stocking Style:** ☐ Open Toe ☐ Closed Toe

Compression Stocking Strength:

☐ **Mild** 8-15mmHg - Persons sitting or standing for extended periods; great for preventative care

☐ **Moderate** 15-20mmHg - Travel, minor swelling, spider veins, pregnancy, minor varicose veins; first time wearers of therapeutic compression stockings.

☐ **Anti-Embolism** 18mmHg - Bed confined or post-surgical, home convalescing individuals

☐ **Firm** 20-30mmHg - Moderate swelling or lymphedema, DVT, post-surgery, pregnancy, moderate varicose veins

☐ **Extra Firm** 30-40mmHg - Severe swelling or lymphedema, DVT, post-surgery, pregnancy, severe varicose veins

Size:	☐ Small	☐ Medium	☐ Large	☐ X-Large	☐ 2X-Large
	Ankle: 7”-8.25” Calf: 11”-14”	Ankle: 8.38”-9.63” Calf: 13.5”-16”	Ankle: 9.75”-11” Calf: 15.5”-18”	Ankle: 11.13”-12.38” Calf: 17.5”-20”	Ankle: 12.5”-13.75” Calf: 19.5”-22”

Color: ☐ Beige ☐ Black ☐ Brown ☐ White ☐ Charcoal ☐ Grey

Notes: _____

_____

By signing below, I deem this Medical Device listed above to be medically necessary and prescribe it to be provided at home for the patient listed.

Physicians Signature: _____ Date: _____

Physicians Printed Name: _____

Fax to 800.486.5633. Please include Patient Demographic Sheet.