bedard MEDICAL SUPPLIES
359 Minot Ave, Auburn, ME 04210
Phone: 207-784-3700
Fax: 207-784-7992

# COMPRESSION THERAPY ORDER FORM

Patient Name:_____ DOB:_____ Phone #:_____

Facility:_____ Fax #:_____

Diagnosis/ICD-10 Code:_____

Duration of Treatment:_____ Quantity:_____ pairs Refill Quantity:_____ pairs

☐ Substitutions Allowed (dispense as written unless checked)

## Please include the *Patient Demographic Sheet* with this order form

**Patient progress notes to support medical necessity are required in order for insurance to approve claim*

**COMPRESSION STOCKINGS**

Circle Appropriate: ☐ Right Leg ☐ Left Leg

Open Venous Statis Ulcer? ☐ Yes ☐ No
(Patient must have an open venous ulcer to qualify for Medicare)

**LEG MEASUREMENTS**

| | Ankle | Calf | Thigh | Length |
|---|---|---|---|---|
| Left | | | | |
| Right | | | | |

**BRAND**

☐ Therafirm ☐ Sigvaris ☐ Jobst Ulcer Care ☐ Jobst Ulcer Care w/ Zipper ☐ Other:_____

**COMPRESSION LEVEL**

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

**STYLE**

☐ Closed Toe ☐ Open Toe ☐ Sleeve ☐ Knee-High ☐ Thigh-High ☐ Pantyhose ☐ Maternity/Plus Sizes

**OTHER PRODUCTS**

☐ Rubber Gloves ☐ Latex-Free Gloves ☐ Donning Device

☐ Other:

**Additional Notes:**_____

_____

_____

**BY SIGNING BELOW, I AUTHORIZE** the use of this document as an order, and I certify that the above prescribed supplies are medically necessary and reasonable.

**Physician Name:**_____ **NPI #:**_____

**Phone Number:**_____ **Fax Number:**_____

**Physician Signature:**_____ **Date:**_____