

Close to you

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www.closetoyou.co

PATIENT NAME: _____ DATE: _____

DIAG. CODE: _____ DIAG: _____

(Required for insurance reimbursement)

Rx

Primary Lymphedema

- ____ Congenital (Milroy's disease)
- ____ Proximal obliteration
- ____ Distal obliteration

Secondary Lymphedema

- ____ Post-mastectomy
- ____ Groin dissection

Venous disorders

- ____ Varicose veins
- ____ Chronic venous insufficiency
- ____ Crural ulcer
- ____ Paralysis of the lower limbs
- ____ Longstanding muscular inactivity

Other _____

HOURS OF TREATMENT IN 24-HOUR PERIOD	TREATMENT AREA
____ 2 Hours	____ Right
____ 4 Hours	____ Left
____ 6 Hours	____ Both
____ 8 Hours	____ Arm
	____ Leg








LINES

- ____ JOBST
- ____ SIGVARIS
- ____ MEDI-USA
- ____ Juzo
- ____ barton/carey

TYPE

- CUSTOM
- READY-TO-WEAR COMPRESSION

_____ mmHg
 (indicate compression)

<input type="checkbox"/>		<input type="checkbox"/>	
	Knee		Waist
<input type="checkbox"/>		<input type="checkbox"/>	
	Knee w/Zipper		Chaps
<input type="checkbox"/>		<input type="checkbox"/>	
	Thigh		Maternity
<input type="checkbox"/>		<input type="checkbox"/>	
			Arm

- LOW 20-30 mmHg
- MODERATE 30-40 mmHg
- HIGH 40 +mmHg

Instructions: _____

Dr.'s Signature: _____ Phone#: _____

See other side for indication