



PLEASE FAX OR E-MAIL THIS REFERRAL FORM AND THE FOLLOWING TO (615) 595-9053 OR INFO@PRETTYINPINKBOUTIQUE.COM

- FACE SHEET INSURANCE CARD IMAGES PLAN OF CARE OFFICE NOTES ANY ADDITIONAL INSTRUCTIONS

PLEASE CALL OR TEXT (615) 777-7465 FOR IMMEDIATE ASSISTANCE COMPLETING THIS FORM

Rx & Certificate of Medical Necessity for LOWER EXTREMITY Compression Garments

PATIENT INFORMATION

Name, Phone, Address, City, State, Zip, Email, Date, Date of Birth, Diagnosis Code, Gender, Duration, Refills, Extremity

DAY GRADIENT COMPRESSION GARMENTS

Circular-Knit (mmHg), Flat-Knit (mmHg), KNEE-HIGH, THIGH-HIGH, FULL WAIST

GRADIENT COMPRESSION WRAPS—NON-ELASTIC SUPPORT GARMENT

Binder Garment with Adjustable Velcro Straps

OTHER GARMENTS

Description, Qty

GRADIENT NIGHT COMPRESSION GARMENT—NON-ELASTIC SUPPORT GARMENT

Night Garment with Foam Core / Channeled Style for Compression

Ready Made, Custom, Specifications

Treatment Plan: The treatment plan for this prescription is for compression garments to be worn during day and/or night on a daily basis as prescribed by the physician.

Certification of Medical Need: The medical equipment herein prescribed is medically necessary to heal and to prevent ulcers/wounds and to contain lymphedema, to prevent ulcers/infection/cellulitis and/or to decrease pain and/or to increase blood flow using gradient pressure.

PHYSICIAN AUTHORIZATION

Therapist Name / Facility, Phone / Fax, Therapist Email, Referring Physician Name, Phone / Fax, Address / City / State / Zip, Physician Signature, NPI, Date