



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 UPPER EXTREMITY Compression Garments

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

DAY GRADIENT COMPRESSION GARMENTS

Circular-Knit (mmHg): 15-20, 20-30, 30-40; Flat-Knit (mmHg): 18-21, 23-32, 34-46
ARM SLEEVE, HAND PIECE, TRUNCAL GARMENT options

GRADIENT NIGHT COMPRESSION GARMENT—NON-ELASTIC SUPPORT GARMENT

Night Garment with Foam Core / Channeled Style for Compression
Options for Left/Right, Ready Made/Custom, Arm Sleeve, Glove, 1-Piece Sleeve/Glove Combination, Outer Jacket, Variable Compression Jacket

VELCRO WRAPS

Options for Arm Sleeve, Hand Piece and Qty

OTHER GARMENTS

Options for Left/Right, Ready Made/Custom, Description, Qty, Other

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