PLEASE FAX OR E-MAIL THIS CLINICAL RESPONSE FORM TO (615) 595-9053 OR INFO@PRETTYINPINKBOUTIQUE.COM
PLEASE CALL OR TEXT (615) 777-7465 FOR IMMEDIATE ASSISTANCE COMPLETING THIS FORM

Clinical Response to Initial Treatment of Lymphedema Pump in Home, Office, or Facility

PATIENT INFORMATION

Name	Date of Birth
Pump ☐ SCD-4004-DL ☐ SCD-4008-DL Garment(s)	
Physician	Protocol _____ mmHg _____ Minutes _____/Day

CLINICAL RESPONSE CONFIRMS MEDICAL NECESSITY

I have reviewed the clinical response data below and confirmed that the device is medically necessary and this document has been added to medical records.

► **Physician Signature**	NPI	Date

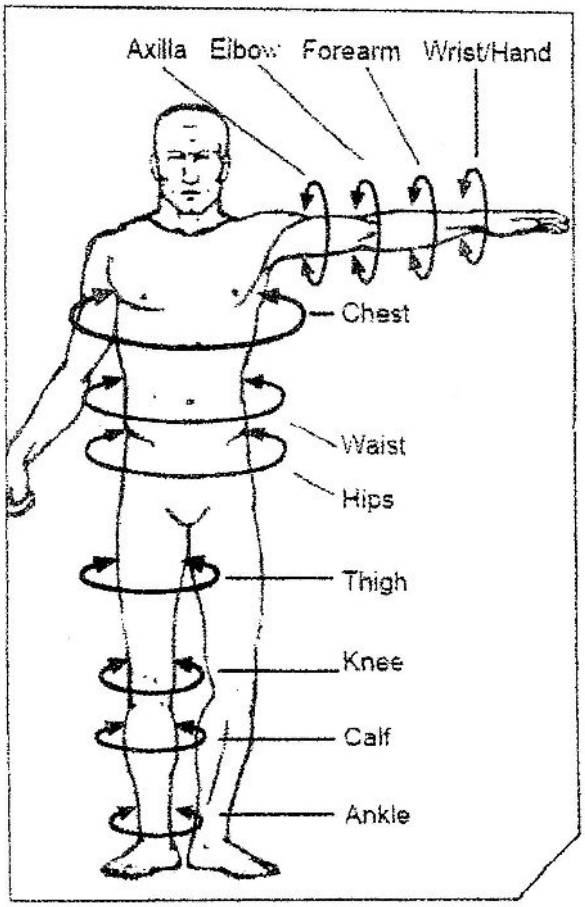
TO BE COMPLETED DURING TRIAL

Date of Treatment	Start Time	End Time	Total Time

Patient and/or Caregiver can apply the device for continued use at home? ☐ Yes ☐ No

Did the patient tolerate the pressure for the entire treatment session? ☐ Yes ☐ No
If No, why not? _____

Other Comments



UPPER EXTREMITY MEASUREMENTS (CM)

	Pre	Post	Difference
Chest			

	Left Arm			Right Arm		
	Pre	Post	Difference	Pre	Post	Difference
Axilla						
Elbow						
Forearm						
Wrist/Hand						

LOWER EXTREMITY MEASUREMENTS (CM)

	Pre	Post	Difference
Waist			
Hips			

	Left Leg			Right Leg		
	Pre	Post	Difference	Pre	Post	Difference
Thigh						
Knee						
Calf						
Ankle						

PATIENT SIGNATURE

► **Patient Signature**	Date