COMPRESSION GARMENT COMPANY

Patient Name _____ Date _____

Diagnosis_____ # of refills_____

Compression (mmHg) circle one

15-20 20-30 30-40 (20-50 velcro wrap) custom

Head and/or Neck: _____

Breast/Chest: _____

compression bra _____

fibrotic pads _____

other _____

Arm: sleeve _____

glove _____

gauntlet _____

other _____

Leg: open toe closed toe patient choice

knee high _____

thigh high _____

pantyhose _____

other _____

Physician Signature _____

Physician Name _____

Thank you for the referral