PLEASE FAX OR E-MAIL THIS REFERRAL FORM AND THE FOLLOWING TO (503) 246-7020 OR INFO@JUSTLIKEAWOMAN.COM

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

PLEASE CALL OR TEXT (503) 246-7000 FOR IMMEDIATE ASSISTANCE COMPLETING THIS FORM

Rx & Certificate of Medical Necessity for UPPER EXTREMITY Compression Garments

PATIENT INFORMATION

Name	Phone	
Address		
City	State	Zip
Email		
Date	Date of Birth	
Diagnosis Code	Gender	
Duration **99 Months / Permanent Use** — Refills	Extremity ☐ Left ☐ Right ☐ Bilateral	

DAY GRADIENT COMPRESSION GARMENTS

Circular-Knit (mmHg): ☐ 15-20 Class 1 ☐ 20-30 Class 2 ☐ 30-40

Flat-Knit (mmHg): ☐ 18-21 Class 1 ☐ 23-32 Class 2 ☐ 34-46 Class 3

ARM SLEEVE ☐ Left, Qty: _____ ☐ Right, Qty: _____	☐ Ready Made ☐ Custom ☐ Silver	☐ Silicone Border (☐ 3cm or ☐ 5cm) ☐ Elbow Dart ☐ Comfort Patch ☐ Slant Top ☐ Other: _____ Color(s): _____
HAND PIECE ☐ **Full Finger (ACFS)** ☐ **Gauntlet Only (AC)** ☐ Left, Qty: _____ ☐ Right, Qty: _____	☐ Ready Made ☐ Custom ☐ Silver	☐ Dorsal Pocket/Pad ☐ Comfort Patch at Thumb ☐ Wrist Extension ☐ Other: _____ Color(s): _____
TRUNCAL GARMENT ☐ Left ☐ Right	☐ Ready Made ☐ Custom	☐ **Compression Bra, Qty: _____** ☐ **Compression Tank/Cami, Qty: _____** ☐ **Compression T-Shirt, Qty: _____** ☐ **Full Vest, Qty: _____** ☐ Other: _____

GRADIENT NIGHT COMPRESSION GARMENT—NON-ELASTIC SUPPORT GARMENT

Night Garment with Foam Core / Channeled Style for Compression

☐ Left ☐ Right	☐ Ready Made ☐ Custom	☐ **Arm Sleeve, Qty: _____** ☐ **Glove, Qty: _____** ☐ **1-Piece Sleeve/Glove Combination, Qty: _____** ☐ Outer Jacket (Adds 10-15 mmHg) ☐ Variable Compression Jacket (20-40 mmHg)

VELCRO WRAPS

☐ **Arm Sleeve**	**Qty: _____**
☐ **Hand Piece**	**Qty: _____**
☐ **Head/Neck**	**Qty: _____**
☐ **Other**	**Qty: _____**

OTHER GARMENTS

☐ 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. Fitter to determine quantities, models, and manufacturers as medically necessary for patient use, lifestyle, and mobility unless otherwise specified. Fitter to accessorize as medically necessary for best patient efficacy.

PHYSICIAN AUTHORIZATION

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