Physician's Written Order – Compression Garments

Physician: ______________________________
NPI: ______________________________
Address: ______________________________
____

Telephone: (______) _________ -- _____________

Patient: _________________ **DOB:**________
Insurer: ___________ **ID#:** _________________
Address: ______________________________
____

Telephone: (______) _________ -- _____________

Supplier: Wound Management, Inc.
NPI: 1295800068
Address: PO Box 271195
Oklahoma City, OK 73137-1195
(T): 1.800.745.2215 **(F):** 1.866.399.9338

Measuring Instructions:

1. Determine length of garments (calf or thigh)
2. For **calf** garments measure: **1**) smallest circumference of ankle, **2**) largest circumference of calf, and **B**) length from knee crease to floor
3. For **thigh** garments measure: **1 & 2 above** plus **3**) largest circumference of thigh and **C**) length 2 inches below gluteal fold to floor
4. Record measurements on order form

Length of Need: _____

LLE **RLE** **BLE**

Strength:

○ 20-30 mmHg
○ 30-40 mmHg
○ 40-50 mmHg

Style:

○ Calf (single layer)
○ Calf (multi-layer)
○ Thigh

Brand:

○ Medi ○ Sigvaris

Inelastic Wrap:

○ Solaris ReadyWrap
○ Sigvaris CompreFLEX LITE
○ CircAid JuxtaLite

Refills: _______

*****NOTE*****
Insurance coverage differs greatly from plan to plan. Please call 1-800-745-2215 with any questions.

For rapid processing, please fax current wound assessment and completed form to 1-866-399-9338 by 3PM Central time.

Diagnosis (select all that apply):

○ **E11.620** (DM2 w/ Diabetic Dermatitis)
○ **E11.621** (DM2 w/ Foot Ulcer)
○ **E11.622** (DM2 w/ other Skin Ulcer)
○ **E11.628** (DM2 w/ Other Skin Complications)
○ **I83.009** (Varicose Veins w/ Ulcer - Unspecified)
○ **I83.10** (Varicose Veins w/ Inflammation)
○ **I83.209** (Varicose Veins w/ Ulcer & Inflammation)
○ **I87.2** (Chronic Venous Insufficiency)
○ **I87.319** (Chronic Venous Hypertension w/ Ulcer)
○ **I87.339** (Chronic Venous Hypertension w/ Ulcer & Inflammation)
○ **I89.0** (Lymphedema, not elsewhere classified)
○ **I97.2** (Post-Mastectomy Lymphedema)
○ **Q82.0** (Hereditary Lymphedema)
○ **R60.9** (Edema, Unspec'd)
○ ___________ Ulcer Code
○ ___________ Ulcer Code
○ ___________ (Other Dx)
○ ___________ (Other Dx)

Extremity Measurements:

LLE

1) __________ cm (ankle)

2) __________ cm (calf)

B) __________ cm (length)

For Thigh:

3) __________ cm (thigh)

C) __________ cm (length)

RLE

1) __________ cm (ankle)

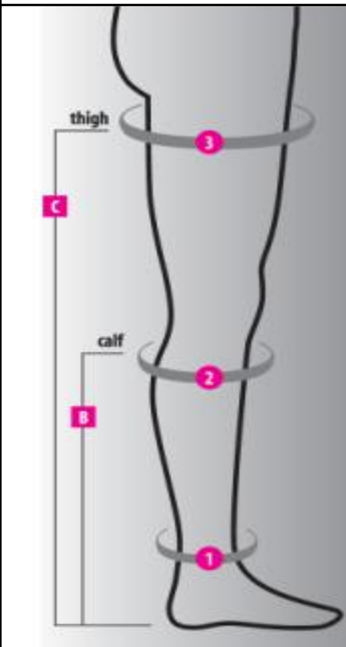
2) __________ cm (calf)

B) __________ cm (length)

For Thigh:

3) __________ cm (thigh)

C) __________ cm (length)



I certify that I am the physician identified on this form. I have reviewed the Physician's Written Order. Any statement on my letterhead or progress notes hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate, and complete to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the product being prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed. My progress notes and other supporting documentation will be provided to the insurer or Authorized Supplier upon request. I understand any falsification, omission, or concealment of facts may subject me to civil or criminal liability. A copy of this order may be retained as part of the patient's medical record.

Physician's Signature ____ Date ____________________