Print Form Reset Form

MyMedSupplies

When completed, please fax to 866.498.9635

Compression Garment Prescription

Provider Name: Client Name:

Phone: Date of Birth:

NPI: Length of need (in months):

ICD-10 and written diagnosis:

Date of Face to Face visit:

Lower Extremity Garments – 2 pairs every 3 months

◯ Knee High ◯ Thigh High ◯ Pantyhose ◯ Maternity Pantyhose

◯ 20-30 mmHg ◯ 30-40 mmHg

Upper Extremity Garments

_____ per year

◯ Gauntlet (select one) ◯ Right ◯ Left ◯ Bilateral

◯ Glove (select one) ◯ Right ◯ Left ◯ Bilateral

◯ Arm Sleeve (select one) ◯ Right ◯ Left ◯ Bilateral

Strength (select one) ◯ 20-30 mmHg ◯ 30-40 mmHg

Prescriber Signature _____ Date_____