

**Prescription/Rx Form for  
 In-Home Vaso-Pneumatic Compression Device**

**Patient's Name:** \_\_\_\_\_

**DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Last Face-to-Face Encounter:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Please check (✓) the conditions that apply to the patient:**

- \_\_\_\_ Lymphedema is Secondary to Chronic Venous Insufficiency [I89.0]
- \_\_\_\_ Lymphedema is Secondary to Cancer, Treatments, or Non-Cancer Surgery [I89.0]
- \_\_\_\_ Lymphedema Secondary to Post-Mastectomy [I97.2]
- \_\_\_\_ Lymphedema is Secondary to Cellulitis, Injury, or Obesity [I89.0]
- \_\_\_\_ Primary Lymphedema (Congenital/Hereditary) [Q82.0] including Lymphedema Tarda
- \_\_\_\_ CVI [I87.2] with Venous Stasis Ulcers [I87.331 Rt or I87.332 Lt]

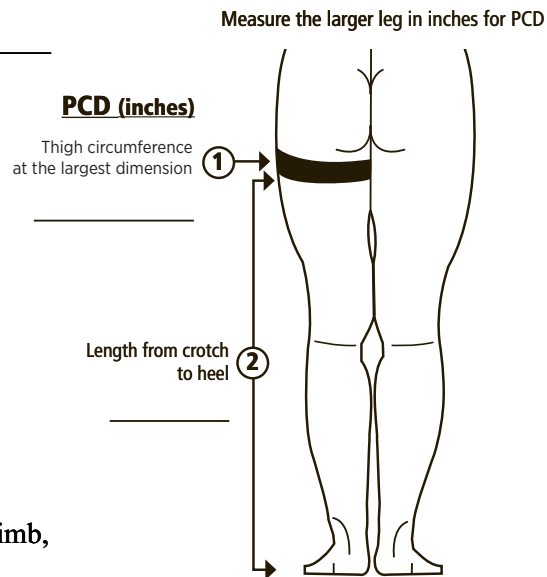
**Measurements needed:**

- 1) Length of leg (crotch to floor) \_\_\_\_ Circumference of thigh \_\_\_\_\_
- 2) Length of arm (shoulder to fingertips) \_\_\_\_\_

**Patient Instructions:**

- \_\_\_\_ 1) Apply to lower extremity,  Right  Left  Bilateral
- \_\_\_\_ 2) Apply to upper extremity,  Right  Left  Bilateral
- \_\_\_\_ 3) Apply to trunk (Bio Pants)
- \_\_\_\_ 4) Apply to chest (Bio Vest)
- \_\_\_\_ 5) Perform one-hour compression therapy, BID.
- \_\_\_\_ 6) Other Instructions : \_\_\_\_\_

**Contraindications:** Acute DVT/PE, uncontrolled CHF, infections in the limb, and active cancer except for palliative care



**Ordering Physician, Nurse Practitioner or Physician Assistant**

**Name:** \_\_\_\_\_ **NPI #:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date of Order:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_



**Please fax signed Prescription/Rx, Progress Notes, and Face Sheet to:**

**VasoCARE @ 866-455-5150**