VasoCARE LLC
Dynamic Compression Medicine
Phone: 800-256-9979

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

Patient's Name: _____

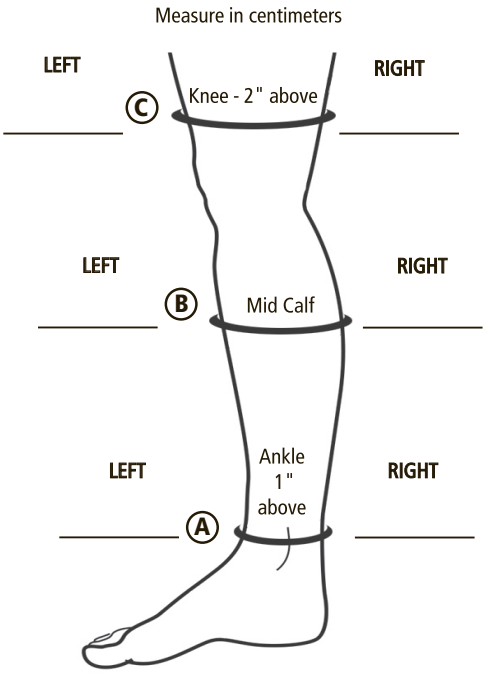
DOB: ____/____/____ **Last Face-to-Face Encounter:** ____/____/____

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)_____
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

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