VasoCARE LLC
Tomorrow's Technology for Today's Medical Needs

Supplier Information
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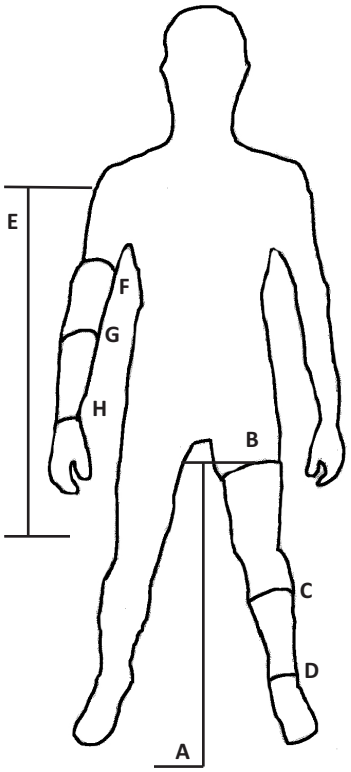
Prescription for an E0651 Pneumatic Compression Therapy Device

Patient's Name: _____DOB: _____ Height: _____ Weight: _____ Phone: _____

Diagnosis:

- ☐ Lymphedema is Secondary to other Causes: 189.0
- ☐ Lymphedema Secondary to Post Mastectomy: 197.2
- ☐ Primary Lymphedema including Tarda: Q82.0
- ☐ Lymphedema due to Chronic Venous Insufficiency: 187.2
- ☐ CVI with Venous Stasis Ulcers {187.331 Rt. or 187.332 Lt.}



Please check which form of measurement: (IN ___) or (CM ___)

Lower Extremity Measurements:

A) Length: (groin to floor) _____ **B)** Circ. of Thigh: Lt. _____ Rt. _____

C) Circ. of Calf: Lt. _____ Rt. _____ **D)** Circ. of Ankle: Lt. _____ Rt. _____

Upper Extremity Measurements:

E) Length of Arm: Lt._____ Rt._____ **F)** Circ. of Arm: Lt. _____ Rt. _____

G) Circ. of Forearm: Lt._____ Rt. _____ **H)** Circ. of Wrist: Lt. _____ Rt. _____

Patient Instructions for Daily Use of Conservative Therapies:

- ☐ Elevate extremities daily and nightly to reduce swelling
- ☐ Exercise and ambulate daily to increase fluid flow and reduce swelling
- ☐ Wear 30-mmHg compression garments/wraps daily to reduce and control swelling

Patient outcome after 4-weeks of conservative therapy for lymphedema:

☐ Condition has NOT improved ☐ Condition improved ☐ **VSUs not improved after 6 months of wound care therapy**

Order/Treatment Instructions: Bio Compression Systems - Pneumatic Compression Device - SC-2004-OC

Apply to lower extremity: ☐ Right ☐ Left ☐ Bilateral

Apply to upper extremity: ☐ Right ☐ Left ☐ Bilateral

Default Pressure Level: 40-60 mmHg, 60 minutes, BID

Contraindications:

Acute DVT, Uncontrolled CHF, Infections in the limb (Cellulitis), & active cancer except for palliative care

FACE-TO-FACE ENCOUNTER CERTIFICATION AND PHYSICIAN SIGNATURE

I certify that this patient is under my care and has been seen within 6 months of the date of this order and supports the need for this medical equipment.

Prescriber: _____ NPI: _____ Date of Order: _____
Please PRINT

Signature: _____ Phone: _____ Fax: _____

Address/City/State/Zip: _____

Received by:

****Above measurements must be included in provider's progress notes****

Please FAX this Rx form, demographics, and clinical notes to: 866-455-5150