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:

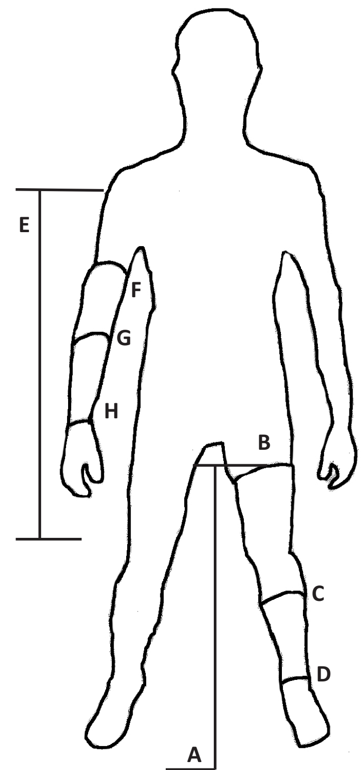
☐ Lymphedema is Secondary to other Causes: 189.0

☐ 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

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