

Prescription/Rx for ordering Comprehensive Pneumatic Compression, Neuromuscular Electrical Stimulation, or DVT Prevention Therapy Program

Patient's Name: _____ DOB: _____ Phone: _____

Pneumatic Compression Therapy Program

Check the corresponding diagnosis:

- Lymphedema is Secondary to other Causes: I89.0
- Lymphedema Secondary to Post Mastectomy: I97.2
- Primary Lymphedema including Tarda: Q82.0
- Lymphedema due to Chronic Venous Insufficiency: I87.2
- CVI with Venous Stasis Ulcers {I87.331 Rt. or I87.332 Lt.}

Patient compliant with instructions:

- Elevate extremities daily to reduce swelling
- Exercise daily to increase fluid flow and reduce swelling
- Wear 30-mmHg compression garments for swelling

**Patient was last seen by physician after a 4-week trial
 of conservative therapies: DATE** ___/___/___

Treatment Instructions: Pneumatic Compression Device - E0651

- Apply to lower extremity: Right Left Bilateral
- Apply to upper extremity: Right Left Bilateral
- Default Pressure Level: 40-60 mmHg, 60 minutes, BID

Neuromuscular Electrical Stimulation Therapy Program

Check the corresponding diagnosis:

- Disuse Muscle Atrophy (M62.561) Right Lower Limb
- Disuse Muscle Atrophy (M62.562) Left Lower Limb
- Nerve supply is intact with the calf muscle: Yes ___ No ___

Limb Pain or Ulcers due to PAD lead to disuse muscle atrophy:

- Claudication Limb Pain due to PAD
- Chronic edema due to Chronic Venous Insufficiency
- Diabetic Foot ulcer due to Arterial Insufficiency
- Restless Leg Syndrome (Movement Disorder due to CVI)

Treatment Instructions: NMES Device - E-0745

- Perform one hour session _____ times per day

DVT Prevention Therapy Program

- Deep Vein Thrombosis/Pulmonary Emboli Prevention

Treatment Instructions:

- Wear DVT device throughout day/evening hours to prevent DVT and manage post-surgical edema until fully ambulatory.

FACE-TO-FACE ENCOUNTER CERTIFICATION

I certify this patient is under my care, has been seen within 6 months of this order, supports the CMS LCD policy, and meets the need of this medical equipment.

Prescriber Name: _____ NPI: _____ Order Date: _____
PRINT

Signature: _____

Address/City/State/Zip: _____

Email: _____ Phone: _____ Fax: _____

Received by:

Please fax: Rx order form, demographics sheet, and clinical notes to:

VasoCARE, LLC @ 866-455-5150