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

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Supplier Information
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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

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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