ALL AMERICAN
Medical Supply Corp.
A 180 Medical Company

Fax: (888) 718-0633 or
Email to: medicalrecords@aa-medsupply.com
Raymond Bartolo - BDM

Standard Written Order - Medical Compression

1 PATIENT INFORMATION

Patient Name: _____ Order Date: ____/____/____

Patient Phone: (____) _____-_____ Date of Birth: ____/____/____

2 DIAGNOSIS

- ☐ I87.2 Venous insufficiency
- ☐ I87.323 Venous hypertension
- ☐ 183.811 Varicose veins of RLE with pain
- ☐ I89.0 Lymphedema
- ☐ I73.9 Peripheral vascular disease
- ☐ 183.812 Varicose veins of LLE with pain
- ☐ Q82.0 Hereditary lymphedema
- ☐ R60.0 Localized edema
- ☐ 183.813 Varicose veins of BLE with pain
- ☐ I97.2 Post-mastectomy syndrome
- ☐ Z86.718 History of other DVT/embolism
- ☐ _____
- ☐ I97.9 Other postprocedural complications and disorders of the circulatory system, not elsewhere classified

3 COMPRESSION LEVEL

☐ 20-30 mmHg ☐ 30-40 mmHg ☐ 40-50 mmHg ☐ _____ mmHg

4 PRODUCT

Lower Extremity Stockings

- ☐ Knee High
- ☐ Thigh High
- ☐ Thigh High (Chaps Style)
- ☐ Waist High/Pantyhose
- ☐ Maternity Pantyhose
- ☐ Open Toe ☐ Closed Toe

Quantity:

Number of Units: _____

Refills: _____

☐ 3-Month Supply

☐ Bilateral ☐ Right ☐ Left

Upper Extremity Garments

- ☐ Arm Sleeve with Silicone Band
- ☐ Arm Sleeve without Silicone Band
- ☐ Gauntlet
- ☐ Glove

Quantity:

Number of Units: _____

Refills: _____

☐ 3-Month Supply

☐ Bilateral ☐ Right ☐ Left

Inelastic Velcro Wraps

- ☐ Calf (ankle to below knee)
- ☐ Foot (foot to ankle)
  - ☐ Toe Caps
- ☐ Knee (knee only)
- ☐ Thigh (above knee to thigh)
- ☐ Full Leg (ankle to thigh)
- ☐ Arm (wrist to axilla)

Quantity:

Number of Units: _____

Refills: _____

☐ 3-Month Supply

☐ Bilateral ☐ Right ☐ Left

Nighttime Garments

Medicare allows two night garments per limb every two years.

- ☐ Upper Extremity – Arm
- ☐ Upper Extremity – Hand
- ☐ Upper Extremity – Arm/Hand
- ☐ Lower Leg and Foot
- ☐ Full Leg and Foot

Quantity:

Number of Units: _____

☐ Bilateral ☐ Right ☐ Left

5 ADDITIONAL COMMENTS _____

6

Provider's Name: _____ NPI: _____

Provider's Phone Number: (____) _____-_____

Provider's Signature: _____ Date: ____/____/____