BLACKBURN'S

HAR-KEL INC. Medical Specialties a division of BLACKBURN'S

COMPRESSION STOCKING FITTING FORM

Please complete all the information below and attach all signed chart notes and patient demographic information

Contact Customer Service with any questions

Tarentum Orders
Phone: 800-472-2440 Fax: 724-230-3705
Erie Orders
Phone: 800-328-9325 Fax: 814-454-2706

PATIENT

First Name: _____ Last Name: _____ Male: ☐ Female: ☐

Address: _____ DOB: _____ HGT: _____ WGT: _____

City: _____ State: ___ Zip: _____ Phone: _____ Alternate Phone: _____

Email: _____ Patient's Preferred Language: ☐ English ☐ Spanish Other: _____

Responsible / Emergency Contact: _____ Emergency Contact Phone: _____

Does the patient have a latex allergy? ☐ Yes ☐ No Has the patient been notified of this order? ☐ Yes ☐ No

Insurance

Primary Insurance: _____ Policy ID # _____ Group # _____ Phone: _____

Secondary Insurance: _____ Policy ID # _____ Group # _____ Phone: _____

Diagnosis

☐ Venous Insuffiency I87.2 ☐ Lymphedema I89.0 ☐ Other _____

☐ Edema R60.0 ☐ Varicose Veins w/ulcer I83.0

PRODUCT SELECTION

TYPE OF PRODUCTS ☐ **Ready to Wear** ☐ **Custom - Erie location only - call for appointment**

☐ TEDS - Antiembolism - Improve blood circulation / Prevent DVT and pulmonary embolism

☐ 15-20 mmHg - Minor Varicosities / Aching/Fatigued Legs / DVT / Minor ankle, leg swelling / Mild Varicosity

☐ 20-30 mmHg - Mild Edema / Post Sclerotherapy / Moderate Varicosity / Mild Venous Insuffuciency / Mild Lymphedema / Lipedema

☐ 30-40 mmHg - Severe Varicosity / Moderate Lymphedema / Moderate Edema / Moderate Venous Insufficiency / Post Surgical / Venous Ulcers

☐ 40-50 mmHg - Severe Lymphedema / Severe Edema / Active Venous Ulcers / Severe Venous Insufficiency / Post Thrombotic

☐ 50+ mmHg - Severe Lymphedema / Elephantiasis / Severe Post Thrombotic

MEASUREMENTS

KNEE HIGH Circumference of ankle: _____ (inches) Circumference of Calf: _____ (inches)
Length Bend of Knee to Floor: _____ (inches)

THIGH HIGH Circumference of ankle: _____ (inches) Circumference of Calf: _____ (inches) Circumference of Mid Thigh: _____ (Inches)
Length Groin to Floor: _____ (inches)

Velcro Closure Compression Wraps

Venous Insufficiency - require wounds *

* Farrow: ☐ Ankle Foot Wrap: ☐ * Juxta Lite ☐ (requires open wound)

Lymphedema Diagnosis

Farrow: ☐ Ankle Foot Wrap: ☐ Medi Juxta Fit: ☐

☐ OPEN WOUND: Measurement: _____ Length _____ Width _____ Depth (inches) Drainage: ☐ None ☐ Min ☐ Mod ☐ Hvy

*

Treatment: _____

REFERRAL INFORMATION

Office Name: _____ Phone: _____

Address: _____ Fax: _____

Contact: _____ Email: _____

How would you prefer to be contacted: ☐ Phone ☐ Fax ☐ Email

BY SIGNING BELOW, I AUTHORIZE the use of this document as an order and I certify that the above prescribed supplies are medically necessary and reasonable. I will maintain an orginal signed and dated copy of this order in my medical records.

Ordering Physician: (Please Print): _____ MD#: _____ NPI: _____

Physician Signature: _____ Date: _____

Duration of Need: ___ (# Months) Start Date: _____ # of Refills: ___