BLACKBURN'S COMPRESSION ORDER FORM

Phone: 800-472-2440 Fax: 724-230-3705
Please contact Customer Service with any questions

Please complete all the information below and attach all patient demographic information

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: _____

Is the patient being seen by a Home Health Agency? ☐ Yes ☐ No Has the patient been notified of this order? ☐ Yes ☐ No

VENOUS ULCER Diagnosis Code: _____

REQUESTED SUPPLIES (Please enter quantity for each supply selected)

Bandages may be covered if there is an Open Venous Stasis Ulcer - Chart Notes and Wound Assessment must be included

HCPC	Description	Quantity	WND #1	WND #2	WND #3
A6441	Artiflex 10cm		☐	☐	☐
A6441	Artiflex 15cm		☐	☐	☐
A6442	Non Sterile Roll Gauze 1"		☐	☐	☐
A6442	Non Sterile Roll Gauze 2"		☐	☐	☐
A6443	Non Sterile Roll Gauze 3"		☐	☐	☐
A6443	Non Sterile Roll Gauze 4"		☐	☐	☐
A6448	Comprilan 6cm		☐	☐	☐
A6449	Comprilan 8cm		☐	☐	☐
A6449	Comprilan 10cm		☐	☐	☐
A6449	Comprilan 12cm		☐	☐	☐
A4452	Tape 1"		☐	☐	☐

HCPC	Description	Quantity	WND #1	WND #2	WND #3
A6457	Tricofix 6cm		☐	☐	☐
A6457	Tricofix 8cm		☐	☐	☐
A6457	Tricofix 10cm		☐	☐	☐
A6457	Tricofix 12cm		☐	☐	☐
A6211	1/4" Grayfoam		☐	☐	☐
A6457	1/2" Grayfoam		☐	☐	☐
A6602	Comprifoam 10cm		☐	☐	☐
A6602	Comprifoam 12cm		☐	☐	☐
A6545	Juxta Lite ___ RT ___ LT		☐	☐	☐
A6545	Farrow Wrap ___ RT ___ LT		☐	☐	☐
	Post Op Shoe Size: _____				

LYMPHEDEMA Diagnosis Code: _____

REQUESTED SUPPLIES (Please enter quantity for each supply selected)

Chart Notes must be included

HCPC	Description	Quantity
A6599	Comprilan 6cm	
A6599	Comprilan 8cm	
A6599	Comprilan 10cm	
A6599	Comprilan 12cm	

HCPC	Description	Quantity
A6602	Comprifoam 10cm	
A6602	Comprifoam 12cm	
A6583	Juxta Fit ___ RT ___ LT	
A6583	Farrow Wrap ___ RT ___ LT	

MEASUREMENTS	Left Leg	Right Leg
Ankle Circumference		
Calf Circumference		
Length from knee to floor		

COMPRESSION WRAPS (Select one along with size)

Juxta Lite HD ☐ SHORT ☐ LONG ☐ S ☐ M ☐ L ☐ XL ☐ XXL

Juxta Fit ☐ SHORT ☐ LONG ☐ S ☐ M ☐ L ☐ XL

Farrow Wrap ☐ REG ☐ TALL ☐ S ☐ M ☐ L ☐ XL

REFERRAL INFORMATION

Office Name: _____ Phone: _____

Address: _____ Fax: _____

Contact: _____ Email: _____

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

BY SIGNING BELOW, I CERTIFY that I am the physician identified in this section and AUTHORIZE *the use of this document as an order.*
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 or Licensed Presciber: (Please Print - Stamps not permitted) _____

Signature: _____ Date: _____ MD# _____ NPI: _____

PRESCRIPTION VALID FOR: **ORDER DATE:** _____ **START DATE:** _____ **Number of Refills:** _____