Therapist Referral for Compression

***Please include current therapy notes as required by Insurance and Face sheet if new patient. ***

Patients name: _____ Date of Referral: _____

DOB: _____ Phone#: _____

Referring Dr.: _____ (who we send RX to)

Referring Therapist: _____

Must have one of these Diagnosis to qualify for products Documented in Medical Records: I89.0 I97.2 Q82.0 I97.89

Type of compression needed:

○ **18/30** ○ **30/40** ○ **40 or Greater**

○ OTC ○ Custom

○ **Right** ○ **Left** ○ **Bilateral**

- ○ Arm Sleeve ○ Gauntlet ○ Glove
- ○ sleeve/glove Combo
- ○ Knee ○ Thigh ○ Chap ○ Waist ○ Toe Cap
- ○ Head/Neck ○ Genital
- ○ Compression Bra
- ○ Foot Wrap ○ Below knee Wrap
- ○ Above Knee Wrap ○ Full Leg Wrap
- ○ Arm Wrap
- ○ Chip Pad _____
- ○ Donning device

Additional Items: _____

_____

- ○ **Nighttime**
- ○ **Padded**
- ○ **Wrap**

  ○ **Right** ○ **Left** ○ **Bilateral**

  ○ Glove ○ Arm ○ bra

  ○ Lower leg w/foot ○ Full leg w/foot
- ○ **Compression Pump**

  ○ Arm ○ Arm w/Shoulder ○ Arm w/chest panel

  ○ Leg ○ Pants

Recommendations:

_____

_____

_____

_____

_____

WOMEN'S HEALTH BOUTIQUE®
DALLAS ~ LONGVIEW ~ OAK CLIFF ~ PLANO ~ TYLER

Store location: _____

WHB Fitter: _____