PROREHAB MEDICAL PRODUCTS

Fax Order to: 978-717-9480

12 Parmenter Road, Unit B6, Londonderry, NH 03053
Phone:617-209-9693 | Fax: 978-717-9480
To Order Online: www.prorehabmed.com
Email Us: emily@prorehabmed.com

COMPRESSION GARMENTS ORDER FORM

DATE: _____

** PLEASE INCLUDE PATIENT INTAKE/FACE SHEET, INSURANCE INFORMATION (CARDS) AND PATIENT CHART NOTES*

REFERRAL INFORMATION

Clinic Name: _____

Contact Name: _____

Phone: _____

Fax: _____

Email: _____

PATIENT INFORMATION

PATIENT NAME: _____

DOB: _____ GENDER: _____

PATIENT PHONE: _____

PATIENT EMAIL: _____

PRIMARY DIAGNOSIS: _____

ALLERGIES (LATEX): _____

PRESCRIBING PHYSICIAN

NAME: _____

PHONE: _____

FAX: _____

MEASUREMENTS

** IF YOU WOULD LIKE TO INCLUDE READY TO WEAR MEASUREMENTS PLEASE LIST BELOW*

**For custom garments-please call for measurements*

UPPER EXTREMITY	LOWER EXTREMITY
CIRCUMFERENCE	**CIRCUMFERENCE**
PALM: _____cm	ANKLE: _____cm
WRIST: _____cm	CALF: _____cm
FOREARM: _____cm	MID THIGH: _____cm
ELBOW: _____cm	WAIST: _____cm
AXILLA: _____cm	**LENGTH**
LENGTH	HEEL TO 2" BELOW KNEE CREASE: _____cm
WRIST TO AXILLA: _____cm	HEEL TO GROIN: _____cm

IN NETWORK PROVIDER FOR:

Medicare
NH Medicaid
Harvard Pilgrim & Health Plans Inc.
Allways Health
Fallon
BMC Healthnet
Health New England
Tricare
Workers Comp
NH Healthy Families
Ambetter
AmeriHealth Caritas
Wellsense

COMPRESSION NEEDED

___ 15-20 mmHg

___ 20-30 mmHg

___ 30-40 mmHg

___ 40-50 mmHg

☐ **Verify Insurance** ☐ **Price Quote** *(if no insurance coverage)*

Please CHECK each product category box for insurance check and/or price quote.

☐ READY TO WEAR COMPRESSION GARMENTS

☐ CUSTOM MADE COMPRESSION GARMENTS

☐ NIGHTTIME COMPRESSION GARMENTS

☐ ALTERNATIVE COMPRESSION (VELCRO, LOW STRETCH)

OTHER _____

_____

☐ UPPER EXTREMITY ☐ LOWER EXTREMITY

☐ **I WANT PROREHAB TO MEASURE FOR CUSTOM GARMENT**

Please check measuring/fitting location.

☐ REFERRAL CLINIC ☐ PROREHAB OFFICE

☐ **I HAVE A PREFERENCE OF PRODUCT(S) FOR MY PATIENT**

If you have a preference of product brand or style for your patient please list them below.

Product #1: _____

Product# 2: _____

Product# 3: _____

Product# 4: _____

ITEM NEEDED:

____ Calf ___ w/Grip Top

____ Thigh

____ Pantyhose

____ Thigh w/Waist Attachment ___L ___R

____ Maternity/Plus Sizes

____ Wraps ___w/Foot Piece

____ Armsleeve __ w/Glove __w/Gauntlet