

**COMPRESSION/LYMPHEDEM PUMP PRESCRIPTION FORM**

NAME \_\_\_\_\_ SEX \_\_\_ PHONE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_ ZIP \_\_\_\_\_  
 DOB \_\_\_/\_\_\_/\_\_\_ PRIMARY PHYSICIAN \_\_\_\_\_ (phone) \_\_\_\_\_  
 COMPRESSION PUMP: \_\_\_\_\_  
 SEGMENTAL APPLIANCE: LEGS: \_\_\_LT \_\_\_RT ARMS: \_\_\_LT \_\_\_RT —  SHOULDER ATTCH.  
 TREATMENT: PRESSURE(S) \_\_\_\_\_ FREQ \_\_\_/DAY \_\_\_\_\_ MIN Length of Necessity: \_\_\_\_\_ mths  
 (99 = purchase)

*PLEASE CHECK ANY CONDITIONS THAT MAY APPLY TO THE PATIENT*

**CHRONIC LYMPHEDEMA DUE TO:**

- POST MASTECTOMY SYNDROME ----- DATE OF SURGERY \_\_\_/\_\_\_/\_\_\_
- OTHER CANCER SURGERY CAUSING SECONDARY LYMPHEDEMA – DATE \_\_\_/\_\_\_/\_\_\_  
DESCRIBE \_\_\_\_\_
- TUMOR(S) OBSTRUCTING LYMPHATIC FLOW  
DESCRIBE \_\_\_\_\_
- POST-RADIATION FIBROSIS CAUSING LYMPHEDEMA – FIRST TREATMENT \_\_\_/\_\_\_/\_\_\_
- PRIMARY LYMPHEDEMA – CONGENITAL / HEREDITARY ----- SINCE \_\_\_/\_\_\_/\_\_\_
- INJURY TO AFFECTED AREA CAUSING LYMPHEDEMA — DATE OF INJURY \_\_\_/\_\_\_/\_\_\_  
DESCRIBE \_\_\_\_\_
- OTHER NON-CANCER SURGERIES ----- DATE \_\_\_/\_\_\_/\_\_\_  
DESCRIBE \_\_\_\_\_
- SCARRING OF LYMPHATIC CHANNELS FROM MULTIPLE EPISODES OF INFLAMMATION
  - CELLULITIS
  - LYMPHANGITIS
- OTHER CAUSES OF SECONDARY (ACQUIRED) LYMPHEDEMA \_\_\_\_\_

**VENOUS DISEASE DIAGNOSIS OPTIONS:**

- CHRONIC VENOUS INSUFFICIENCY
  - WITH** A HISTORY OF VENOUS STASIS ULCERS
 

<u>LOCATION</u>	<u>SIZE</u>		<b>CONTINUOUSLY PRESENT?</b>
_____	_____	DATES: from _____	to present
_____	_____	DATES: from _____	to present

**\*\* MUST ANSWER \*\***

**Y / N ARE THERE CONSERVATIVE TREATMENTS SUCH AS, COMPRESSION STOCKINGS/WRAPPINGS, ELEVATION AND/OR PHYSICAL THERAPY DOCUMENTED IN YOUR PROGRESS NOTES?**

PRESCRIBING PHYSICIAN: (please print) LAST \_\_\_\_\_ FIRST \_\_\_\_\_

NPI #: \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_

**\*\*PLEASE INCLUDE WITH THE ORDER:**

- 1. YOUR FAX COVER SHEET**
- 2. PATIENT DEMOGRAPHICS**
- 3. LAST 3 OR 4 CHART NOTES**

## **Instructions for completion of Compression Pump Order:**

***PLEASE INCLUDE WITH EVERY ORDER:***

- 1. YOUR FAX COVER SHEET - This helps us communicate the status with you directly.***
- 2. PATIENT DEMOGRAPHICS & INSURANCE INFORMATION***
- 3. OFFICE NOTES: Please include notes from the last three office visits and, if available, patient history.***

***\*\*\*SPECIAL NOTE: When prescribing the pump for Venous Stasis Ulcers, if the patient has Medicare the ulcer must be reoccurring for at least 6 months.***

### ***CONTRAINDICATIONS INCLUDE:***

- Congestive Heart Failure (CHF) - pump can still be used if cleared by cardiologist.***
- Deep Vein Thrombosis***
- Inflammatory Phlebitis or during episodes of Pulmonary Embolism***
- Peripheral Arterial Disease***
- Infection of the limb without appropriate antibiotic coverage***
- Presence of Lymphangiosarcoma***