LEWIN MEDICAL SUPPLY
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STANDARD WRITTEN ORDER – MEDICAL COMPRESSION

PATIENT NAME: _____ DOB: _____

☐ (I83.813) Varicose Veins of Bilateral Lower Extremities with Pain ☐ (I87.2) Venus Insufficiency (Chronic) (Peripheral)

☐ (I89.0) Lymphedema ☐ (I83.899) Varicose Veins of Unspecified Lower Extremities with Other Complications

☐ (I83.93) Asymptomatic Varicose Veins of Bilateral Lower Extremities ☐ (R60.9) Edema, Unspecified

☐ (R60.0) Localized Edema ☐ Other Diagnosis _____

Quantity:

☐ 8 Pairs ☐ 4 Pairs ☐ 2 Pairs ☐ Other _____

NUMBER OF REFILLS (Length of Need): ☐ every 6 months ☐ per year ☐ 99 (Lifetime)

COMPRESSION (mmhg)

☐ 15-20 ☐ 20-30 ☐ 30-40 ☐ 40-50 ☐ Other _____

LOWER EXTREMITY ☐ Closed Toe ☐ Open Toe ☐ Patient Choice
☐ Calf/Knee ☐ Thigh ☐ Pantyhose ☐ Thigh w/ Waist L ☐ R ☐

ADDITIONAL NOTES:

_____

_____

_____ _____ _____
Physician Signature (***No Stamps***) **(Required)** **NPI#** **Order Date**

Physician Name (please print): _____

Office Address: _____