Northeast Medical Products, Inc

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An Innova Medical Group Company

INNOVA MEDICAL PRODUCTS

COMPRESSION STOCKINGS (READY TO WEAR) PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

DOB _____ Height _____ Weight _____

Diagnosis Code _____ Length of Need _____

Alternate Contact Name _____ Relationship _____ Phone _____

COMPRESSION (CIRCLE ONE)			
8-15 mmHg	15-20 mmHg	20-30 mmHg	30-40 mmHg
STYLE (CIRCLE ONE)			
KNEE	THIGH	WAIST	MATERNITY
FULL FOOT		**OPEN TOE**	

Quantity (Pair) _____ Number of Refills _____

Measurements

	LEFT	RIGHT
Ankle		
Calf		
Thigh		
Length		
Hip		
Fitter Initials	**Date/Time**	

PLEASE SUPPLY A COPY OF THE NOTES FROM THE FACE-TO-FACE VISIT
(ALL CLINICAL NOTES NEED TO BE EITHER ELECTRONICALLY SIGNED OR HAVE A WET SIGNATURE)

Physician Name _____ NPI _____

Address _____

Phone _____ Fax _____

_____ _____
Physician Signature Date