



Pneumatic Compression Device Referral Form and Rx

Patient Name _____

DOB _____ Phone _____

Address _____

City _____ State _____ Zip _____

Diagnosis/ICD-9 Code: _____ Length of Need: 99= Lifetime

457.0 Post-Mastectomy Lymphedema

457.1 Other Lymphedema (Milroy's Disease infant-<13 yrs)

757.0 Congenital or Primary Lymphedema

459.11 Post-Phlebitic Syndrome with Ulcer*

454.0 Varicose Vein with Ulcer*

459.81 Chronic Venous Insufficiency*

*Documentation must include location and size of active ulcer.

Dispense Pneumatic Compression Device and sleeve for (check and circle)

Arm Left Right Bilateral

Leg Left Right Bilateral

<p>Pressure (20-80 mmHg)</p> <p><input type="checkbox"/> 20-30 mmHg</p> <p><input type="checkbox"/> 30-40 mmHg</p> <p><input type="checkbox"/> ____ mmHg</p>	<p>Pause (10 – 70 seconds)</p> <p><input type="checkbox"/> 10–20 seconds</p> <p><input type="checkbox"/> 20-30 seconds</p> <p><input type="checkbox"/> ____ seconds</p>
<p>Duration</p> <p><input type="checkbox"/> 45 minutes per session</p> <p><input type="checkbox"/> 60 minutes per session</p> <p><input type="checkbox"/> __ minutes per session</p>	<p>Frequency</p> <p><input type="checkbox"/> Daily</p> <p><input type="checkbox"/> Twice a day</p> <p><input type="checkbox"/> Three times a day</p>

Please fax this form with demographic sheet, insurance information and clinical notes that verify:

- For lymphedema: 4 week trial of conservative therapy without relief
- For venous insufficiency: 6 month trial of conservative therapy without relief

Physician/Provider (Print) _____

Physician/Provider Signature _____

License # _____ **Date** _____

Erie, PA:	1700 Peach Street	(814) 877-6121	Fax: (814) 455-9440
Bradford, PA:	600 Chestnut Street	(814) 362-8141	Fax: (814) 362-9113
Meadville, PA:	303 Chestnut Street	(814) 337-6900	Fax: (814) 455-9440
Jamestown, NY:	512 W. Third Street	(716) 664-5092	Fax: (716) 664-6570
Fredonia, NY:	37 West Main Street	(716) 672-4704	Fax: (716) 672-4706