RX

PRAIRIE MEDICAL

Compression Therapy Prescription

Patient Name: _____ Date: _____

Patient Phone: _____ Diagnosis: _____

Compression Style

☐ Calf Length	☐ Arm Sleeve	☐ Toe Caps
☐ Thigh High	☐ Glove/Gauntlet	☐ Neck
☐ Pantyhose	☐ Chest/Underarm	☐ Head
☐ Shorts	☐ Abdomen	☐ Custom
☐ Capris	☐ Velcro System	☐ Swell Spot

Specifics: _____

_____

Compression Strength

☐ 10-15 mmHg ☐ 20-30 mmHg ☐ 30-40 mmHg

☐ Donning/Doffing Device(s)

Physician Information

Prescriber/Referral Name: _____

Signature: _____ ***Dispense as Written***

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