INCLUDE THE PATIENT'S DEMOGRAPHIC AND MEDICAL RECORD TO AVOID DELAYS. PLEASE FILL OUT THE ENTIRE FORM. Email completed form to **referrals@prism-medical.com.**

PRISM Home Medical Supply Specialists | Ames Walker Live Healthy. Live Happy.

PHONE: (888) 244-6421 FAX: (855) 250-5813
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(SECTION 1) GENERAL INTAKE INFORMATION

PATIENT NAME: _____ ***ORDER START DATE:*** ___/___/____
PATIENT PHONE: (_____)_____ PATIENT DOB: _____/_____/_____
REFERRAL FACILITY: _____ CITY:_____ STATE:____
REFERRAL PHONE: (_____)_____ FAX: (_____)_____

(SECTION 2) DIAGNOSIS INFORMATION

*****TO ENSURE ELIGIBILITY FOR INSURANCE COVERAGE, THE SUBMITTED MEDICAL RECORD MUST CONFIRM THE INFORMATION PROVIDED BELOW.*****

LOCATION BEING TREATED: ☐ **LEFT LEG** ☐ **RIGHT LEG** ☐ **LEFT ARM** ☐ **RIGHT ARM**

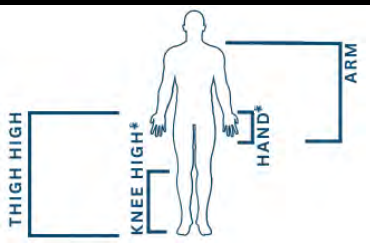
- ☐ I89.0 SECONDARY LYMPHEDEMA DUE TO: _____ (*ETIOLOGY*)
- ☐ I97.2 SECONDARY LYMPHEDEMA POST-MASTECTOMY
- ☐ Q82.0 PRIMARY LYMPHEDEMA (CONGENITAL/HEREDITARY) INCLUDING LYMPHEDEMA TARDA
- ☐ I97.89 POSTPROCEDURAL COMPLICATIONS AND DISORDERS OF THE CIRCULATORY SYSTEM:_____ (*ETIOLOGY*)

DURATION OF NEED ☐ **LIFETIME** ☐ **OTHER, PLEASE EXPLAIN:** _____

(SECTION 3) MEASUREMENTS AND 'READY TO WEAR' LYMPHEDEMA PRODUCTS

LOWER EXTREMITY MEASUREMENTS (cm)

ANKLE (CIRC.)	_____LT	_____RT *
CALF (CIRC.)	_____LT	_____RT *
LENGTH (HEEL TO KNEE)	_____LT	_____RT *
THIGH (CIRC.)	_____LT	_____RT
LENGTH (HEEL TO BUTTOCKS)	_____LT	_____RT



UPPER EXTREMITY MEASUREMENTS (cm)

* PALM (CIRC.)	_____LT	_____RT
* WRIST (CIRC.)	_____LT	_____RT
ELBOW (CIRC.)	_____LT	_____RT
AXILLA (CIRC.)	_____LT	_____RT
LENGTH (WRIST TO AXILLA)	_____LT	_____RT

*****QUANTITY (QTY) MUST BE INCLUDED IN THE MEDICAL RECORD // DAYTIME ALLOWABLES: 3 PER LIMB ~ 6 MONTHS // NIGHTIME ALLOWABLES: 2 PER LIMB ~ 2 YEARS*****

KNEE-HIGH	THIGH-HIGH	ARM/HAND
DAYTIME GARMENT	***DAYTIME GARMENT***	***DAYTIME GARMENT***
_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY
_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY
_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY
NIGHTIME GARMENT	***NIGHTIME GARMENT***	***NIGHTIME GARMENT***
_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY
_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY
COMPRESSION LEVEL	***COMPRESSION LEVEL***	***COMPRESSION LEVEL***
18-30 mmHg ☐LT ☐RT	18-30 mmHg ☐LT ☐RT	18-30 mmHg ☐LT ☐RT
30-40 mmHg ☐LT ☐RT	30-40 mmHg ☐LT ☐RT	30-40 mmHg ☐LT ☐RT
>40 mmHg ☐LT ☐RT	>40 mmHg ☐LT ☐RT	>40 mmHg ☐LT ☐RT
BANDAGING		
_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY
_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY
_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY	_____ ☐LT ☐RT ____QTY

(SECTION 4) NOTES

(SECTION 5) SUPPLY ASSESSMENT

DOES THE PATIENT CURRENTLY HAVE ANY OF THE REQUESTED PRODUCT(S) AT HOME? ☐ **YES** ☐ **NO**

IS THE PATIENT REQUESTING COORDINATION OF CARE? ☐ **YES** ☐ **NO**
(THE PATIENT HAS CHOSEN PRISM TO ASSIST IN PROVIDING THE REQUESTED CARE BY EITHER; PROVIDING PRODUCT, VERIFYING INSURANCE BENEFITS, BILLING FOR SERVICE(S) OR COORDINATING CARE SHOULD DIRECT SERVICE NOT BE AN OPTION.)

(SECTION 7) PROVIDER SIGNATURE

PROVIDER'S NAME:_____
PROVIDER'S NPI:_____
SIGNATURE:_____
DATE:_____/_____/_____

****(If the PROVIDER listed herein is best reached at a location other than the referring facility detailed in Section 1, please provide the PROVIDER'S contact information below.)***
PROVIDER PHONE: (_____)_____
PROVIDER FAX: (_____)_____
PROVIDER EMAIL: (_____)_____