INCLUDE THE PATIENT'S DEMOGRAPHIC AND MEDICAL RECORD TO AVOID DELAYS. **PLEASE FILL OUT THE ENTIRE FORM.**

PHONE: (888) 244-6421 FAX: (800) 975-6321
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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

ARM, HAND*, KNEE HIGH*, THIGH HIGH

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: (________)______________________________