REFERRAL FOR PNEUMATIC COMPRESSION

Tactile MEDICAL®

Referring clinic information:

Clinic:

Clinic Account #: FC

Clinic fax number:

Referring clinician (if other than prescriber):

Best contact for referring clinician (phone/email):

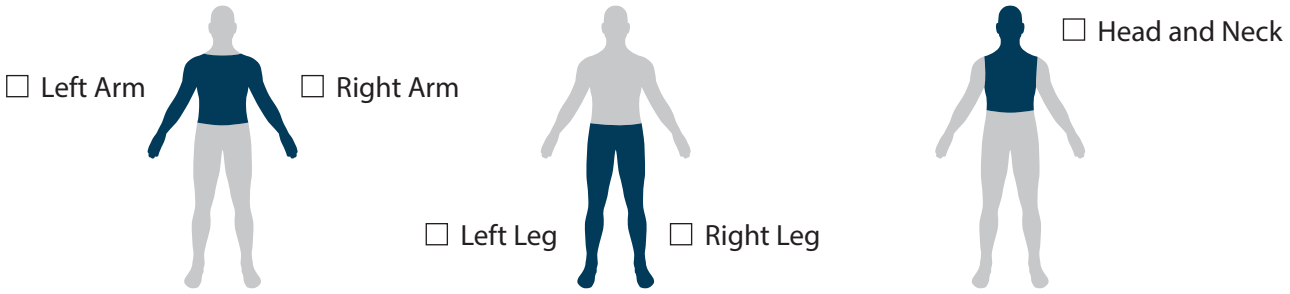
Prescribing physician:

1. Patient name: _____ DOB: _____

2. Please include the following when faxing in your order:

- ☐ Patient Demographic Sheet
- ☐ Insurance Card (or insurance information)
- ☐ Signed Patient Consent form (if available)
- ☐ Records (if required by payer)

3. Location of edema:



4. Optional notes:

_____

_____

Your local Tactile Medical Sales Representative:

Name: Email:

Phone: Fax:

Tactile Medical
3701 Wayzata Blvd, Suite 300
Minneapolis, MN 55416 USA

Toll Free Tel: 833.382.2845 (833.3TACTILE)
Toll Free Fax: 866.435.3949

Hours: 7 a.m. to 7 p.m. CT, Monday–Friday
tactilemedical.com

To order please securely fax all information to 866.435.3949 or call 866.435.3948