REFERRAL FOR PNEUMATIC COMPRESSION



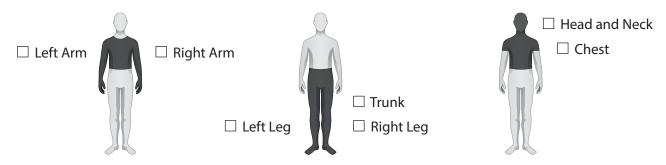
Referring clinic information:

1. Patient name:	DOB:
Prescriber:	
Best contact for referring clinician (phone/email):	
Referring clinician (if other than prescriber):	
Clinic fax number:	
Clinic Account #: FC	
Clinic:	

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

- □ Patient Demographic Sheet
- □ Insurance Card (or insurance information)
- □ Signed Patient Consent form (if available)
- Chart Visit Notes/Medical Records/Other Lymphedema related documentation, girth measurements, skin condition(s), duration and type of conservative treatments tried but failed to improve symptoms (e.g., most insurances require the patient to try 4-weeks of compression garments, exercise, and elevation).

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	Customer Care Text or Call: 612.355.5100 Toll Free Phone: 833.3TACTILE (833.382.2845)	To order please securely fax all information

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