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):

Prescriber:

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)
- ☐ 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:

☐ Left Arm ☐ Right Arm

☐ Left Leg ☐ Trunk ☐ Right Leg

☐ Head and Neck ☐ Chest

4. Optional notes:

_____

_____

Your local Tactile Medical Sales Representative:

Name: Email:

Phone: Fax:

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

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