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: _____

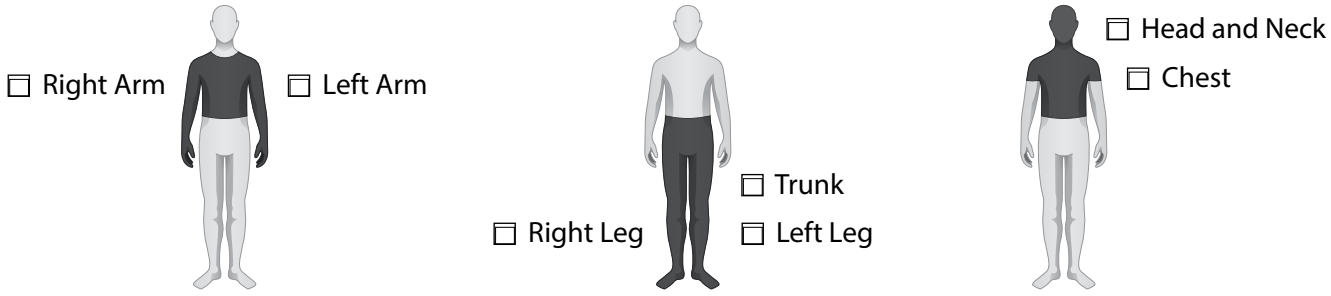
Is patient currently seen at a VA clinic? If yes, name of clinic: _____

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 and description of ongoing symptoms/results of prior treatments (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

tactilemedical.com

Customer Care
Text or Call: 612.355.5100
Toll Free Phone: 833.3TACTILE (833.382.2845)
Fax: 612.355.5101/ Toll Free Fax: 866.435.3949
Email: customerservice@tactilemedical.com
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