

PRESCRIPTION FORM

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*Your Lymphedema Pump Specialist
and Therapeutic Brace Authority*

PATIENT INFORMATION

Patient Name: _____

Street Address: _____ DOB: ____/____/____ Phone (____) ____-____

City: _____ State: _____ Zip: _____

DIAGNOSIS _____ Length of Need: _____ Date: ____/____/____

EXTREMITY ☐ Left ☐ Right ☐ Pair Quantity _____ This product is a medical necessity and requires a diagnosis for insurance reimbursement.

COMPRESSION

☐ SUPPORT 15-20mmHg

Aching/Fatigued Legs, mild
Edema, mild ankle and foot
Pregnancy, prophylactic
Varicosity mild

☐ 20-30mmHg

Aching/Fatigued Legs
Burn Scar Management
DVT
Edema, mild
Hypertrophic Scar
Lymphedema, mild
Lipedema
Pregnancy
Sclerotherapy, post
Varicosity, moderate
Venous Insufficiency, mild
Venous Ulcers

☐ 30-40mmHg

Burn Scar Management
DVT/Post Thrombotic
Edema, moderate
Lymphedema, moderate
Lipedema
Orthostatic Hypotension
Phlebectomy, post
Pregnancy, pronounced
varicosities or edema
Sclerotherapy, post
Surgical, post
Varicosity, severe
Venous Insufficiency, moderate
Venous Ulcers

☐ 30-50mmHg

Edema, severe
Lymphedema, severe
Lipedema
Post Thrombotic
Venous Insufficiency, severe
Venous Ulcers, active

COLOR

☐ Black

☐ Sand

STYLE

☐ Open Toe ☐ Closed Toe ☐ Day ☐ Night



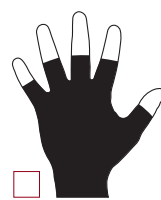
Knee



Thigh



Arm Sleeve



Hand Gauntlet



Glove



Calf

COMPRESSION WRAP

Please complete measurements on reverse side.

PRESCRIBING PHYSICIAN

Last: _____ First: _____ Phone (____) ____-____

Signature: _____ NPI #: _____

Please include the following with prescription: Patient Demographics (Name, Address, Date of Birth, etc.);
Copy of Insurance cards (Primary and Secondary, if applicable); Chart Notes clearly stating the need for Garment.



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SIZING CHART and MEASUREMENTS

INSTRUCTIONS: Use centimeters with a standard measuring tape completing all necessary measurements for product.

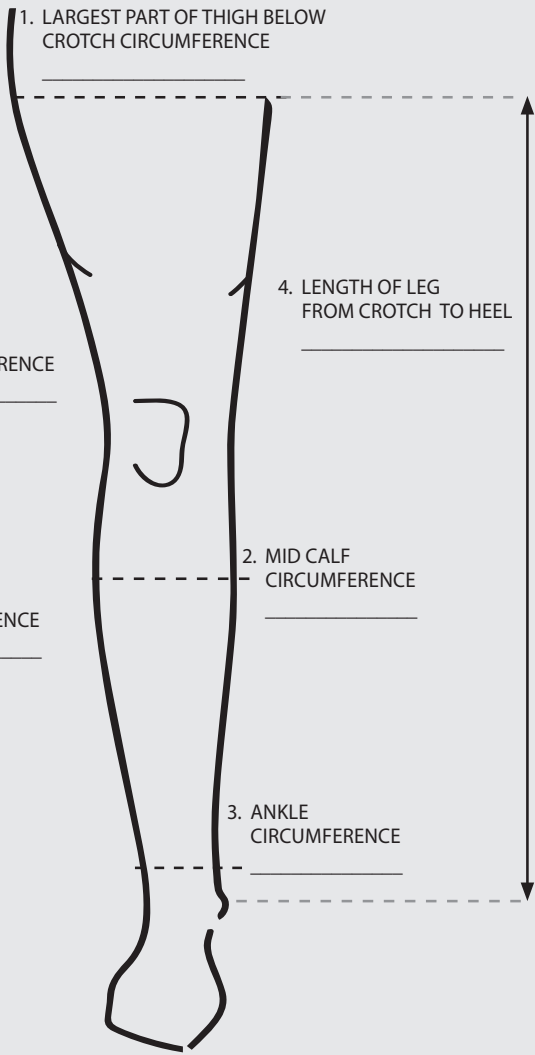
NOTE: Please indicate, in area below, any unusual measurements pertinent to the fitting.



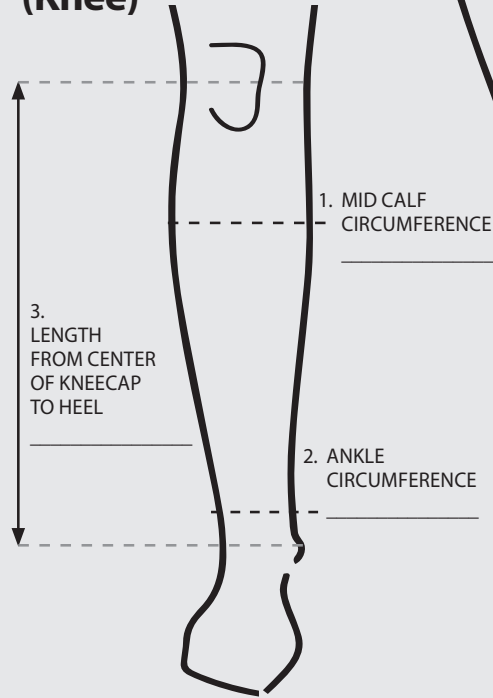
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LOWER EXTREMITY *in centimeters*

Full Leg

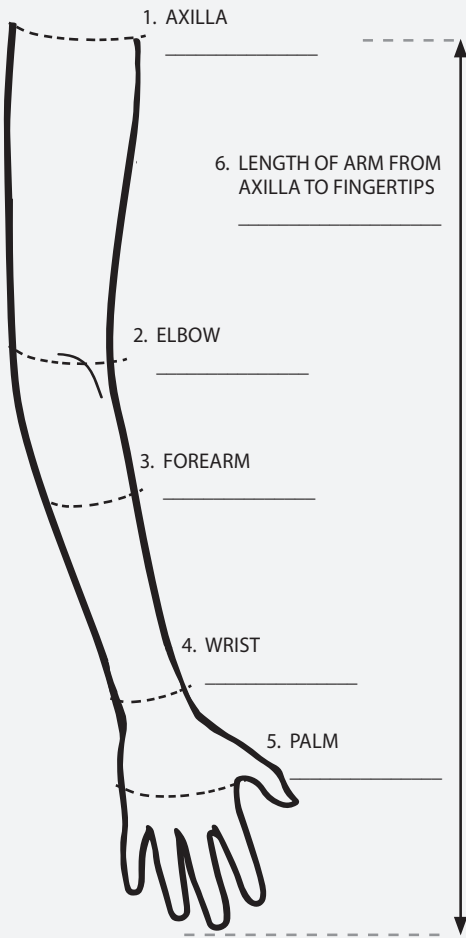


Compression Sock (Knee)

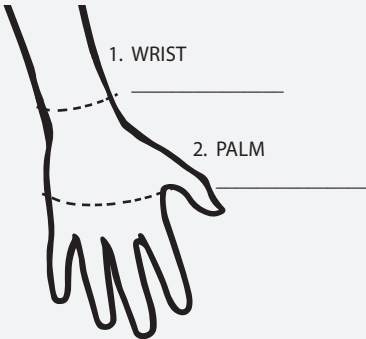


UPPER EXTREMITY *in centimeters*

Full Arm



Hand



PATIENT INFORMATION

Special Physical Characteristics: _____



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