VasoCARE LLC
Tomorrow's Technology for Today's Medical Needs

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Supplier Information
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Prescription/Rx for ordering Pneumatic Compression Devices (PCD), or Neuromuscular Electrical Stimulation Devices.

Progress notes must be attached and faxed along with this completed Rx form.

Patient's Name: _____ DOB: _____ Phone: _____

☐ Pneumatic Compression Device

Check the corresponding diagnosis:

_ Lymphedema is Secondary to other Causes: I89.0

_ Lymphedema Secondary to Post Mastectomy: I97.2

_ Primary Lymphedema including Tarda: Q82.0

_ Lymphedema due to Chronic Venous Insufficiency: I87.2

_ CVI with Venous Stasis Ulcers {I87.331 Rt. or I87.332 Lt.}

Patient compliant with instructions:

☐ Elevate extremities daily to reduce swelling

☐ Exercise daily to increase fluid flow and reduce swelling

☐ Wear 30-mmHg compression garments for swelling

Patient was last seen by physician after a 4-week trial of conservative therapies: DATE _____/_____/_____

Treatment Instructions: ___ E0650/E0651 ___ E0652 (calibrated pressure)

☐ Apply to lower extremity: __ Right __ Left __ Bilateral

☐ Apply to upper extremity: __ Right __ Left __ Bilateral

☐ Default Pressure Level: 40-60 mmHg, 60 minutes, BID

☐ VeinOPlus Vascular Device

Check the corresponding diagnosis:

_ Disuse Muscle Atrophy (M62.561) Right Lower Limb

_ Disuse Muscle Atrophy (M62.562) Left Lower Limb

_ Disuse muscle atrophy due to lack of walking due to chronic disease or injury.

_ Nerve supply is intact with the calf muscle.

Limb Pain or Ulcers due to PAD lead to disuse muscle atrophy:

- Claudication Limb Pain due to PAD
- Chronic edema due to Chronic Venous Insufficiency
- Diabetic Foot ulcer due to Arterial Insufficiency
- Restless Leg Syndrome (Movement Disorder due to CVI)

Treatment Instructions: NMES Device - E-0745

☐ Perform one hour session _____ times per day

FACE-TO-FACE ENCOUNTER CERTIFICATION

I certify this patient is under my care, has been seen within 6 months of this order, supports the CMS LCD policy, and meets the need of this medical equipment.

Prescriber Name: _____ NPI: _____ Order Date: _____
PRINT

Signature: _____

Address/City/State/Zip: _____

Email: _____ Phone: _____ Fax: _____

PLEASE FAX: Rx order form, demographics, and clinical notes to:

VasoCARE, LLC @ 866-455-5150

OR

Email: orders@vasocare.com

www.vasocare.com