PATIENT INFORMATION

Patient's Name: _____

Date of Birth: ___/___/_____

SURGICAL TYPE

☐ Partial Mastectomy

☐ **RT** ☐ **LT** ☐ **BI LATERAL**

☐ Mastectomy

☐ **RT** ☐ **LT** ☐ **BI LATERAL**

☐ Reconstruction

☐ **RT** ☐ **LT** ☐ **BI LATERAL**

In order to have complete records indicating Medical Necessity for each of our patients we ask you to complete the following prescription with DOCTOR'S SIGNATURE - NPI - DATE - DIAGNOSIS CODE. We cannot dispense product without this RX completed. Thank You!

☐ This patient is requesting that you contact them to set up an appointment. **Please contact:** _____

Rx

Doctor's Printed Name: _____ NPI#: _____

Doctor's Signature: _____ Date: _____

Diagnosis Code: **Right Side:** _____ EXPIRES:_____

Left Side: _____

COMPRESSION

☐ L8010 Lymphedema Sleeve
QTY____ No. of Refills _____

☐ A6549 Compression Garment
QTY____ No. of Refills _____

☐ A4465 Non-elastic Binder for Extremity
QTY____ No. of Refills _____

BREAST PROSTHESIS

☐ L8015 Post-Surgical Camisole with Mastectomy Form
QTY____ No. of Refills _____

☐ L8020 Post-Surgical/Non-Silicone Breast Prosthesis
QTY____ No. of Refills _____

☐ L8030 Silicone Breast Prosthesis
QTY____ No. of Refills _____

☐ L8032 Nipple Prosthesis, Reusable, Any Type
QTY____ No. of Refills _____

☐ L8035 Custom Breast Prosthesis
QTY____
No. of Refills _____

MASTECTOMY BRA

☐ L8000 Mastectomy Bra without integrated Breast Form, Any Size, Any Type
QTY____ No. of Refills _____