Byram HEALTHCARE

Lymphedema

Acct Name _____ **Referral #** _____

Customer Service 844-385-0408 ext. 33408 **Fax** 800-642-4639

****Please Include the Patient's Demographic Information and Medical Record to Expedite Delivery****

Patient

☐ Face Sheet Attached D.O.B. _____ Order Date _____

Name *(L)* _____ *(F)* _____ Ordered by _____

Diagnosis

Location Being Treated: ☐ Lt Leg ☐ Rt Leg ☐ Lt Arm ☐ Rt Arm **Duration of Need:** ☐ Lifetime ☐ Other _____

☐ I89.0 Lymphedema Due to: (Etiology) _____

☐ I97.2 Postmastectomy Lymphedema Syndrome

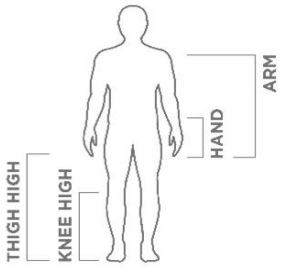
☐ Q82.0 Congenital/Hereditary Lymphedema Including Tarda

☐ I97.89 Postprocedural Complications and Disorder of the Circulatory System: (Etiology) _____

Measurements for Standard (Ready to Wear) Lymphedema Products

Lower Extremity

Ankle circ. (cm)		LT		RT
Calf circ. (cm)		LT		RT
Length, Heel to Knee (cm)		LT		RT
Thigh circ. (cm)		LT		RT
Length, Heel to Buttocks (cm)		LT		RT



Upper Extremity

Palm circ. (cm)		LT		RT
Wrist circ. (cm)		LT		RT
Elbow (cm)		LT		RT
Axilla Circ. (cm)		LT		RT
Length, Wrist to Axilla (cm)		LT		RT

*****Quantity must be documented in the medical record*****

	DAY: 3 per body part per 6 mths	LT (ea)	RT (ea)	mmHg	LT	RT	NIGHT: 2 per body part per 24 mths	LT (ea)	RT (ea)
Knee High	Select Product	0	0	18-30	☐	☐	Select Product	0	0
	Select Product	0	0	30-40	☐	☐	Select Product	0	0
				>40	☐	☐			
Thigh High	Select Product	0	0	18-30	☐	☐	Coming Soon	0	0
	Select Product	0	0	30-40	☐	☐	Coming Soon	0	0
				>40	☐	☐			
Arm/Hand Ankle/Foot	Select Product	0	0	18-30	☐	☐	Select Product	0	0
	Select Product	0	0	30-40	☐	☐	Select Product	0	0
				>40	☐	☐			

Accessories	LT (ea)	RT (ea)	Bandaging	LT (ea)	RT (ea)
Select Product			Select Product		
Select Product			Select Product		

Notes

The provider has prescribed the item(s) set forth in this order, based on the provider's measurements, for treatment of the patient's lymphedema diagnosis.

Prescriber

(L) _____ *(F)* _____ NPI _____

Phone (___) _____ Fax (___) _____ email: _____

Signature **X** _____ **Date** _____ Print

I certify that I am the treating clinician identified on the form. Any statement on my letterhead attached hereto, has been reviewed and sighed by me. I certify that the medial necessity information above contained herein is true, accurate and completer, to the best of my knowledge, and is consistent with the information contained in my clinical records for the Patient and/or in the Patient's permanent medial record.