Standard Written Order (SWO)
Lymphedema Compression Treatment Items

Patient Information

NAME: _____ **DOB:** _____

DIAGNOSIS:

- ☐ I89.0 Lymphedema, not elsewhere classified
- ☐ I97.2 Postmastectomy lymphedema syndrome
- ☐ Q82.0 Hereditary lymphedema
- ☐ I97.89 Other postprocedural complications and disorders of the circulatory system, not elsewhere classified

Daytime Compression Garments (*qty 3 every 6 months*)

SIDE:

☐ Left ☐ Right ☐ Both

TYPE:

☐ Ready-To-Wear ☐ Custom

COMPRESSION LEVEL:

_____

CHECK ALL THAT APPLY:

☐ Glove ☐ Gauntlet ☐ Sleeve ☐ Torso/shoulder ☐ Bra ☐ Head and Neck
☐ Foot ☐ Toe cap ☐ Knee ☐ Thigh ☐ Waist ☐ Genital

ACCESSORIES NEEDED:

☐ Silicone bands ☐ Donning aids ☐ Other: _____
☐ Padding/Inserts ☐ Zippers

Nighttime Compression Garments (*qty 2 every 2 years*)

SIDE:

☐ Left ☐ Right ☐ Both

TYPE:

☐ Ready-To-Wear ☐ Custom

CHECK ALL THAT APPLY:

☐ Glove ☐ Gauntlet ☐ Sleeve ☐ Torso/shoulder ☐ Bra ☐ Head and Neck
☐ Foot ☐ Toe cap ☐ Knee ☐ Thigh ☐ Waist ☐ Genital

ACCESSORIES NEEDED:

☐ Silicone bands ☐ Donning aids ☐ Other: _____
☐ Padding/Inserts ☐ Zippers

Compression Wraps

SIDE:

☐ Left ☐ Right ☐ Both

CHECK ALL THAT APPLY:

☐ Arm ☐ Bra
☐ Foot ☐ Below knee ☐ Above knee ☐ Full leg

QUANTITY: _____

REFILLS: _____ **PHYSICIAN SIGNATURE:** _____ **DATE:** _____

INSTRUCTIONS:

_____
_____
_____
_____
_____
_____

PHYSICIAN NAME: _____

NPI: _____

ADDRESS: _____

_____

PHONE: _____

FAX: _____