# Garment Communication Form
# **For Use by Lymphedema Therapists**

## Patient Information

**NAME:** _____ **DOB:** _____

**PHONE:** _____

## **Daytime** Compression

**SIDE:**

☐ Left ☐ Right ☐ Bilateral

**TYPE:**

☐ Ready-To-Wear ☐ Custom

☐ Adjustable Compression Wrap/Velcro:

_____

**KNIT-TYPE:**

☐ Circular-knit ☐ Flat-knit

**CHECK ALL THAT APPLY:**

☐ Sleeve ☐ Glove ☐ Gauntlet ☐ Vest/Bra ☐ Torso/Shoulder ☐ Head and Neck

☐ Knee High ☐ Thigh High ☐ Waist ☐ Capri ☐ Shorts ☐ Genital ☐ Toe Caps

**COMPRESSION LEVEL:**

☐ Class I ☐ Class II ☐ Class III ☐ Class IV

**ACCESSORIES NEEDED:**

☐ Silicone bands ☐ Donning aids ☐ Swell pad

☐ Padding/Inserts ☐ Zippers ☐ Other: _____

**DOCUMENTATION TO SUPPORT MEDICAL NECESSITY:**
(ie: Lymphedema severity, skin integrity, wounds, mobility restrictions, custom justification)

_____

_____

_____

## **Nighttime** Compression

**SIDE:**

☐ Left ☐ Right ☐ Bilateral

**TYPE:**

☐ Ready-To-Wear ☐ Custom

☐ Adjustable Compression Wrap/Velcro:

_____

**CHECK ALL THAT APPLY:**

☐ Sleeve ☐ Glove ☐ Gauntlet ☐ Vest/Bra ☐ Torso/Shoulder ☐ Head and Neck

☐ Knee High ☐ Thigh High ☐ Waist ☐ Capri ☐ Shorts ☐ Genital ☐ Toe Caps

**ACCESSORIES NEEDED:**

☐ Silicone bands ☐ Donning aids ☐ Swell pad

☐ Padding/Inserts ☐ Zippers ☐ Other: _____

**DOCUMENTATION TO SUPPORT MEDICAL NECESSITY:**
(ie: Lymphedema severity, skin integrity, wounds, mobility restrictions, custom justification)

_____

_____

_____

## Therapist Contact Info

**NAME:** _____ **PHONE:** _____

**ADDRESS:** _____ **FAX:** _____

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*Form description: This form is a tool for lymphedema therapists to communicate patient compression needs clearly and effectively to the DME provider/retailer.*