WWW.Bandagesplus.com
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(305) 477-0062—Phone (305) 592-0061—FAX

Lymphedema Patient Intake Form

Patient Name: _____DOB: _____Date: _____

Address:_____City_____ST:_____Zip:_____

Phone Number: _____Cell Number: _____

Email: _____

Facility/Physician/Therapist (Practitioner) Information:

Referring Practitioner Name: _____Practitioner's Specialty: _____

Referring Practitioner Phone #: _____Referring Practitioner Fax #: _____

Primary Physician Name: _____ Primary Physician Specialty: _____

Primary Physician Phone #: _____ Primary Physician Fax #: _____

Primary Insurance:

Insurance: _____ ID#: _____ Group#: _____

Insurance Phone #: _____

Subscribers Name: _____ DOB:_____

Secondary Insurance:

Insurance: _____ ID#: _____ Group#: _____

Insurance Phone #: _____

Subscribers Name: _____ DOB:_____

Diagnosis Information:

Has the type/classification of lymphedema been diagnosed? ____ yes ____ no

Has the stage of lymphedema been diagnosed? ____ yes ____ no

Prescribed Products:

___ Daytime ___ Nighttime compression garments.

___ Bandaging and bandaging supplies.

___ Other.

Product Description (including item #, compression and qty):

Item #1_____Qty _____
Item #2_____Qty _____
Item #3_____Qty _____

Comments:

_____
_____
_____
_____