

Therapist Referral for Compression

Please include current therapy notes as required by Insurance and Face sheet.

Patients name: _____ Date of Referral: _____

DOB: _____ Phone: _____

Referring Dr.: _____ (who we send RX to)

Referring Therapist: _____ Contact # or Email: _____

Please Fax to (430)558-5856 or Email to referrals@mywhb.com

Email fitters only for additional information or questions please don't send questions to above email.

All Referrals will now be processed by referrals team Prior to going to store.

Must have one of these Diagnosis to qualify for products Documented in Medical Records: I89.0 I97.2 Q82.0 I97.89

DAY TIME GARMENTS

18/30 30/40 40 or Greater

Right Left Bilateral

- Arm Sleeve Gauntlet Glove
- sleeve/glove Combo
- Knee Thigh Chap Waist Toe Cap
- Head/Neck Genital
- Compression Bra _____
- Foot Wrap Below knee Wrap
- Knee Wrap Thigh Wraps Full Leg Wrap
- Arm Wrap Hand/gauntlet wrap
- Chip Pad _____
- Donning device _____

Additional Items: _____

NIGHTTIME GARMENTS

Padded Wrap

Right Left Bilateral

Glove Arm bra

Lower leg w/foot Full leg w/foot

Compression Pump

- Arm Arm w/Shoulder Arm w/chest panel
- Leg Pants

Recommendations:



WHB ONLINE