





800-248-2229 OPTION 1 FAX TO: 800-552-9443

Compression Order Form

Patient Name:					_ Gender: M or F				
Patient Address:					D.O.B:				
Patient Phone:					Diagnosis:				
Provider Name:					Provider's NPI #:				
Provider Signature:					Date:				
Elastic Compression:									
1.	Length:	ength: Calf/Knee		Thigh	Pantyhose		Quantity	Quantity:	
2. Compression level (see chart below): 1			15-20mmHg	20-30mmHg 30-40mmHg					
Circaid/Velcro Wrap:									
1.	Length:	Calf		Thigh	Full Leg		Quantity	Quantity:	
2.	Circaid style:	Juxtalite	Juxtafi	t Essentials	Juxtafit Premi	um	Reduction Kit	Custom	
Please Fax order with Patient's Insurance information to Advanced Medical Solution at 810-225-8062.									
Or the patient can bring this script to our Retail Location at 7575 W. Grand River Ave. Brighton, MI 48116									
Questions? Call Advanced Medical Solutions at: 810-225-7701. We participate and bill most Insurances.									



