Rx **Standard Written Order (SWO) <u>All fields are required for insurance approval.</u>**

inbox@sunmedmedical.com
FAX 800-715-5422 | Phone 855-477-4507

Patient Name: ____ **Date of Birth:** ______________
(Last) (First) (M)

Patient Cell # ______________________________ **Patient Home #** ______________________________

Patient Address: ____

Upper Extremity ☐ Left ☐ Right ☐ Bilateral

Check all that are applicable:

☐ Accessory for gradient compression garment or wrap with adjustable straps, not-otherwise specified Qty: _____
☐ Gradient compression arm sleeve and glove combination, custom, each Qty: _____
☐ Gradient compression arm sleeve and glove combination, each Qty: _____
☐ Gradient compression arm sleeve, custom, heavy weight, each Qty: _____
☐ Gradient compression arm sleeve, custom, medium weight, each Qty: _____
☐ Gradient compression arm sleeve, each Qty: _____
☐ Gradient compression garment, arm, padded, for nighttime use, custom, each Qty: _____
☐ Gradient compression garment, arm, padded, for nighttime use, each Qty: _____
☐ Gradient compression garment, bra, for nighttime use, custom, each Qty: _____
☐ Gradient compression garment, bra, for nighttime use, each Qty: _____
☐ Gradient compression garment, glove, padded, for nighttime use, custom, each Qty: _____
☐ Gradient compression garment, glove, padded, for nighttime use, each Qty: _____
☐ Gradient compression garment, neck/head, custom, each Qty: _____
☐ Gradient compression garment, neck/head, each Qty: _____
☐ Gradient compression garment, not otherwise specified Qty: _____
☐ Gradient compression garment, torso, and shoulder, each Qty: _____
☐ Gradient compression garment, torso/shoulder, custom, each Qty: _____
☐ Gradient compression gauntlet, custom, each Qty: _____
☐ Gradient compression gauntlet, each Qty: _____
☐ Gradient compression glove, custom, heavy weight, each Qty: _____
☐ Gradient compression glove, custom, medium weight, each Qty: _____
☐ Gradient compression glove, each Qty: _____
☐ Gradient compression wrap with adjustable straps, not otherwise specified Qty: _____
☐ Gradient pressure wrap with adjustable straps, arm, each Qty: _____
☐ Gradient pressure wrap with adjustable straps, bra, each Qty: _____
☐ Other______________ Qty: _____

Diagnosis: ☐ I89.0 ☐ Q82.0 ☐ I97.2 ☐ I97.89
 # Refills (per 12 months): _________

MD Name (Printed): ________________________________ **NPI#:**______________________________

Address: ____

Phone: ____________________________ **Fax:** ___________________________

Physician Signature Required: ______________________________________ **Date:** ______________

Notes: ____