Medical Compression Sleeve Prescription

SIGVARIS

Client Name:

USL Reference Number:

Date:

Purchase Order Number:

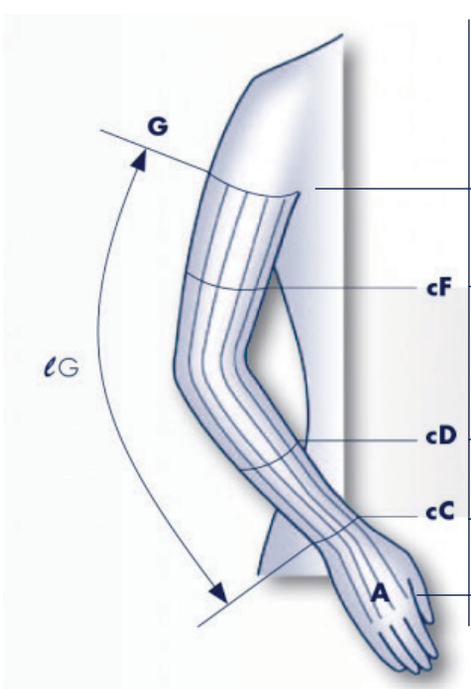
Prescriber name and contact details:

Please fax or email this form to:

USL Medical
494 Rosebank Road, Auckland 1026, New Zealand
Attention: Linda Thomas
Fax: 0800 830 660
Phone: 0800 658 814
Email: sigvaris@uslmedical.co.nz

Medical condition that requires compression stockings:

Model	Compression mmHg			Styles Available		
	14 – 18	20 – 25	23 – 32	Softtop	Griptop	Mitten
Traditional						
Advance						



Length (i.e. ℓD)

ℓG ..... cm

cF ..... cm

cD ..... cm

cC ..... cm

cA ..... cm

Charge to client: Yes ☐ No ☐

Send direct to client: Yes ☐ No ☐

Client Phone Number. _____

Address:

Name of Fitter:

Size: Length:

Code. _____

For internal use only

cF = Circumference of the arm at the thickest place
cF = Circumference of the arm at mid forearm

*Take measurements first thing in the morning when possible