WeCare for AbetterU Medical Supply
Your body. Your journey. Our priority.

Compression Garments

Please fax completed form to WeCare for AbetterU
at: Fax: 925-462-5600.

PLEASE PROVIDE DEMOGRAPHIC AND INSURANCE INFORMATION.

Date Prescribed: _____ Gender ❑ Male ❑ Female

Patient's Preferred Language ❑ English ❑ Spanish ❑ Russian ❑ Other _____

Patient Name: _____ DOB: _____

Address: _____ Apt/Suite # _____

City: _____ State: _____ Zip:_____ Phone: _____

Cell: _____ Email: _____

Insurance: _____

Diagnosis: _____ Length of need: _____

PLEASE SELECT COMPRESSION LEVEL

❑ 30-40 mmHg ❑ 40-50 mmHg

❑ KNEE HIGH COMPRESSION STOCKINGS
MEASUREMENTS
(Circumference of ankle and calf. Length from the floor to the bend of the knee)

	ANKLE CIRCUMFRENCE (INCHES)	CALF CIRCUMFRENCE (INCHES)	LEG LENGTH (INCHES)
LEFT			
RIGHT			

❑ THEIGH HIGH COMPRESSION STOCKINGS
MEASUREMENTS
(Circumference of ankle, calf, and knee. Length from the floor to the gluteal fold)

	ANKLE CIRCUMFRENCE (INCHES)	CALF CIRCUMFRENCE (INCHES)	THEIGH CIRCUMFRENCE (INCHES)	LEG LENGTH (INCHES)
LEFT				
RIGHT				

REFERRAL INFORMATION

Physician's Signature: _____Date: _____/_____/_____

Physician's Name (Please Print)_____NPI#_____

Address_____

Phone _____ Fax _____