

Prescription and Certification of Medical Necessity
Vasopneumatic Compression system

Patient Name: _____ Date of Birth: _____

Primary Diagnosis: _____ ICD-9 Code: _____

Date of Surgery: _____ Date of Injury: _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Ankle Wrap (bilateral) | <input type="checkbox"/> Knee Wrap (Bilateral) | <input type="checkbox"/> Low Back Wrap |
| <input type="checkbox"/> Shoulder Wrap (Left) | <input type="checkbox"/> Elbow Wrap (Bilateral) | <input type="checkbox"/> Shoulder Wrap (Right) |
| <input type="checkbox"/> Wrist Wrap (Bilateral) | <input type="checkbox"/> Bent Elbow (Bilateral) | <input type="checkbox"/> Other |

The pneumatic compression system has the ability to reduce pain, muscle spasms, tissue damage, swelling and helps accelerate the healing process. Flexible fabric wraps simultaneously deliver cyclical compression and temperature controlled cold therapy. The cyclical pneumatic compression technology limits the initial swelling and helps to remove swelling by forcing tissue debris and fluid into and along the lymphatic system. It lowers oncotic pressure and promotes fluid re-absorption. Cold therapy minimizes pain and decreases tissue damage by reducing cell metabolism. The pneumatic compressor has easy adjustable temperature, pressure, and treatment time settings. Due to the local anesthetic value of this product, narcotics use and subsequent rehabilitation costs are reduced.

RX: Vasopneumatic Compression System (Game Ready)

- Edema following injury or surgery can be effectively managed using a Vasopneumatic compression system.
- Vasopneumatic compression system and exercise will help reverse the edema and prevent its accumulation.
- Reduction of pain, swelling, muscle spasm and the decrease of metabolism and oxygen needs of the injured tissue.

Prescription

Length of Prescription: _____ **(Estimated) From:** _____

I, the undersigned, certify that the following prescribed equipment is medically necessary to this patient's well being. The equipment is both reasonable and necessary in reference to accepted standards of medical practice in treatment of this patient's condition and is not prescribed as "convenience" equipment.

Physician Signature: _____ **Date:** _____

Physician Name: (please print) _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Fax:** _____