Midwest LTC
A Guardian Pharmacy®

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Compression Stockings Form

Date: _____

Patient Name: _____ **Date of Birth:** _____

Compression Stocking RX - _____ Pairs

___ 15-20 mmHg

___ 20-30 mmHg

___ 30-40 mmHg

___40-50 mmHg

___ 50-60 mmHg _____

___ Knee High

___ Thigh High

Diagnosis:

___ Edema: R60-9

___ Venous Insufficiency: I87-2

___ Other: _____ ICD-10 _____

Number of Refills: _____

Physician Signature: _____

_____

Facility Use Circumference of: Ankle _____ Calf _____ Thigh _____

Length – Bottom of heel to bend in the back of the knee: _____

Bottom of heel to gluteal furrow (when standing): _____