McKesson Patient Care Solutions Inc.

LYMPHEDEMA PUMP EVALUATION FORM
FOR LOWER EXTREMITIES

T 800.451.6510 F 800.749.0711

Patient Name:_____ Date:_____

Height:_____ Weight:_____ DOB:_____

Treating Physician:_____ Phone:_____

PCP:_____ Phone:_____

Wound Care Center:_____

FAX COMPLETED FORM AND COMPRESSION PUMP PRESCRIPTION TO MPCS AT 1-800-749-0711.

Patient Medical History

1. Does the patient have open wound(s)? ❑ Yes ❑ No
   If yes, what length of time? ❑ 6 months ❑ Longer
   Are wounds draining? ❑ Yes ❑ No
   How often does patient change dressing(s)? _____
2. Has the patient had cancer, cancer surgery or radiation treatment?
   ❑ Yes ❑ No
3. Has the patient used compression therapy in the past?
   ❑ Yes ❑ No
   If yes, has the patient used the following?
   ❑ Support stockings ❑ Compression wraps
   ❑ Massage/Elevation/Exercise ❑ Lymphedema pumps
4. Does the patient have Lymphedema? ❑ Yes ❑ No
5. Does the patient have a physical deformity or abnormality in any of the affected areas? ❑ Yes ❑ No
   If yes, please call MPCS Customer Service at 1-800-451-6510 (Press 3) to ensure the correct products are ordered.
6. Does the patient have any history of the following:
   Blood Clots (DVT - Deep Vein Thrombosis) ❑ Yes ❑ No
   If yes, when was the Doppler Study? _____
   What were the results? _____
   Cellulitis ❑ Yes ❑ No
   If yes, when was the patient diagnosed? _____
   Is patient receiving treatment? ❑ Yes ❑ No
   CHF (Congestive Heart Failure) ❑ Yes ❑ No
   CVI (Chronic Venous Insufficiency) ❑ Yes ❑ No
   Diuretics ❑ Yes ❑ No
   Open wounds ❑ Yes ❑ No

Notes _____

Lymphedema Pump Information

Pump: ❑ Bio Compression 2004 ❑ Bio Compression 3004
❑ Lympha Press Petite ❑ Other

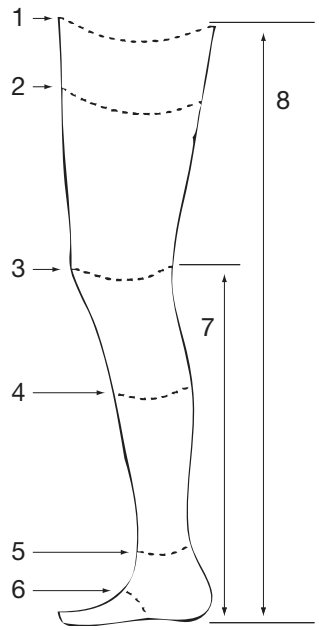
Settings and Pressure: Distal _____ Medial _____ Medial _____ Proximal _____

Frequency of use and duration:

❑ 1 per day ❑ 30 minutes
❑ 2 per day ❑ 1 hour
❑ 3 per day ❑ 1 1/2 hours
❑ 4 per day ❑ 2 hours

***If ordering custom sleeves and proper measurements are not provided to MPCS, MPCS is not responsible for costs associated with subsequent custom orders for this patient.**

❑ **Bilateral** ❑ **Left** ❑ **Right**



❑ Left	❑ Right
1. _____in.	1. _____in.
2. _____in.	2. _____in.
3. _____in.	3. _____in.
4. _____in.	4. _____in.
5. _____in.	5. _____in.
6. _____in.	6. _____in.
7. _____in.	7. _____in.
8. _____in.	8. _____in.

- Provide measurements in inches*.
- Measure circumference using a standard measuring tape.
- Measure length accurately, as straight as possible.
- For bilateral condition, complete both columns.
- For best results, measure in the morning or immediately after compression therapy.

_____
Name of person completing form *(Required)*

_____
Signature

_____
Date