PRESCRIPTION ORDER FORM

All orders must be faxed or e-mailed.
Fax: 1-877-877-8168
Email: orders@absolutemedical.net
For Questions: 1-855-624-9270

Prescription Order Form must accompany all Jobst Elvarex, Elvarex Soft Orders

For both Elvarex and Elvarex Soft a certified fitter number is required. ***Call 1-855-624-9270 to learn more about Certification Training***

❶ **Date** _________ ☐Original Order ☐Reorder with Changes ☐Exact Reorder

❷ **Model** ☐Elvarex ☐Elvarex Soft ❸ **Gender** ☐Male ☐Female

❹ **Diagnosis** ☐Edema ☐Lymphedema ☐Stasis Ulcer ☐Varicose Veins ☐Varicose Veins ☐Vein Ligation

☐Orthostatic Hypotension ☐Thrombotic Syndrome ☐Arterial Insufficiency ☐Other

❺ **Order Confirmation**

Fax # ________________________ Email Address: ____

❻ **Patient Information:**

Name ____

Address ___________________________________ City/State/Zip ____________________________

Date of Birth (month/day/year): ___________ **Phone#:** ________________

❼ **Prescribing Physician Name:** ____

❽ **Measured by:** ____________________________________ Phone#: __________________________

❾ **Fitter #:** __________________________ Facility: ____

❿ **Bill To :** ____

Address ____ City ______________________________

State __________ Zip Code ________________ Country ______________

If paying by credit card ☐Amex ☐Mastercard ☐Visa ☐ Discover ☐ Other

Card # ____ Expiration Date: ______________

CVV/CVC/CID Code: ______________