Absolute Medical. 1843 W Hubbard St #2A
Chicago, IL 60622
Tel: 312 233 2207 Fax: 866 860 9358
To Order Online: orders@absolutemedical.com
Our website: absolutemedical.com

Patient Last Name: ______________ Patient First Name: ______________

Fitter Last Name: ______________ Fitter First Name: ______________

Date: ____________________

ORDER FORM

DATE: ______________

☐ **Verify Insurance** ☐ **Price Quote** *(if no insurance coverage)*

Please CHECK each product category box for insurance check and/or price quote.

- ☐ READY TO WEAR COMPRESSION GARMENTS
- ☐ CUSTOM MADE COMPRESSION GARMENTS
- ☐ NIGHTTIME COMPRESSION GARMENTS
- ☐ ALTERNATIVE COMPRESSION (VELCRO, LOW STRETCH)
- ☐ PNEUMATIC COMPRESSION DEVICE (PUMP)
- ☐ BANDAGE SUPPLIES
- ☐ UPPER EXTREMITY ☐ LOWER EXTREMITY

MEASUREMENTS

** IF YOU WOULD LIKE TO INCLUDE READY TO WEAR MEASUREMENTS PLEASE LIST BELOW*
** IF YOU MEASURED FOR CUSTOM GARMENTS PLEASE INCLUDE MANUFACTURERS FORM WITH THIS ORDER FORM*

UPPER EXTREMITY	LOWER EXTREMITY
CIRCUMFERENCE	**CIRCUMFERENCE**
PALM: ________cm	ANKLE: ________cm
WRIST: ________cm	CALF: ________cm
FOREARM: ________cm	MID THIGH: ________cm
ELBOW: ________cm	WAIST: ________cm
AXILLA: ________cm	
LENGTH	**LENGTH**
WRIST TO AXILLA: ________cm	HEEL TO 2" BELOW KNEE CREASE: _____cm
	HEEL TO GROIN: _____cm

** PLEASE INCLUDE PATIENT INTAKE/FACE SHEET, INSURANCE INFORMATION (CARDS) AND PATIENT CHART NOTES*

☐ **I WANT ABSOLUTE MEDICAL TO MEASURE MY PATIENT**

Please check measuring/fitting location.

☐ REFERRAL CLINIC ☐ ABSOLUTE MEDICAL OFFICE

☐ **I HAVE A PREFERENCE OF PRODUCT(S) FOR MY PATIENT**

If you have a preference of product brand or style for your patient please list them below.

Product #1: ______________________________

Product# 2: ______________________________

Product# 3: ______________________________

Product# 4: ______________________________

ORDER COMMMENTS: ______________________________

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