Pure Day Upper Extremity Order Form

PURE MEDICAL
OUR COMMITMENT. YOUR COMFORT.

PATIENT INFORMATION

Name: | Phone Number: | Order Date:

Therapist /Fitter: Name: | Phone Number:

Email: | Reorder of Order #: | Measurement Date:

GARMENT

Style PD - UE -

☐ Left Arm ☐ Right Arm

☐ Thumb Slit ☐ Full Thumb

C=

Compression

☐ 20-30 mmHg ☐ 30-40 mmHg

☐ Other

Modifications **Placement Instruction**

☐ No Silicone ☐ 1/2 Silicone ☐ Silicone

☐ Zippers

BILLING INFORMATION

☐ Quote Only

Business Name:

Phone: Fax:

Contact Name:

Account #: P.O. #:

Payment:

☐ Credit card ☐ Net 30

Card #:

Exp: SID:

SHIPPING INFORMATION

Shipping:

Requested Delivery Date:

☐ Standard ☐ Priority

Ship to:

Attn:

Street:

City: State: Zip:

Phone:

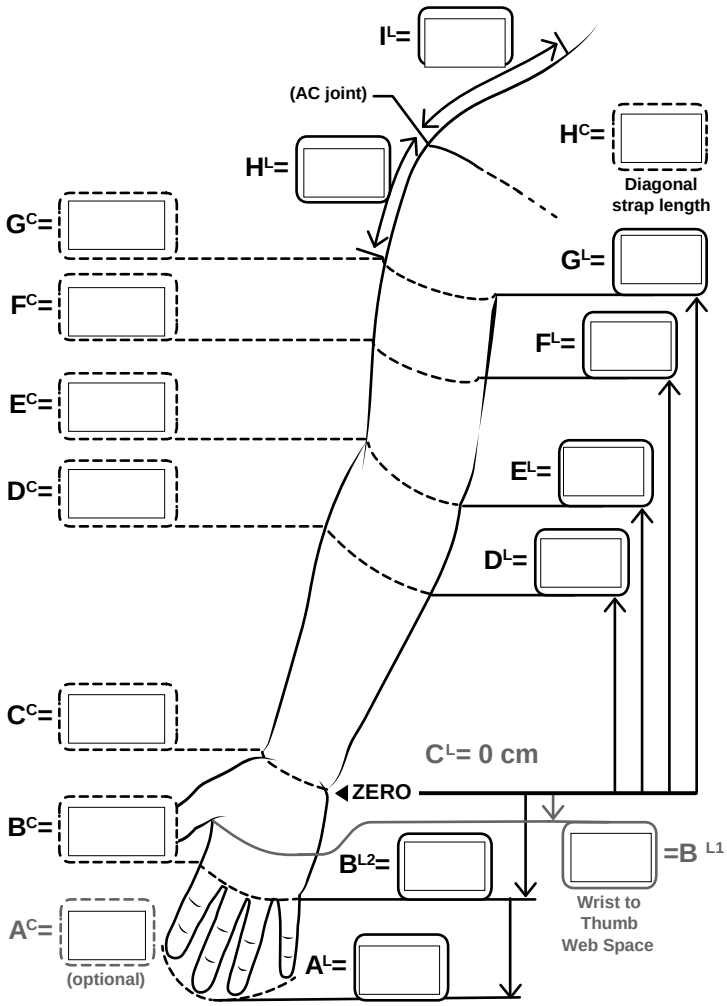
Email:

(for shipping notification)

MEASUREMENTS

(All measurements in centimeters)

C = Circumference L = Length



Notes:

Email : pureorders@puremedical.us or Fax: 414-928-5315

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