



Asheville: 828-785-1881 Phone; 828-785-1882 Fax
Waynesville: 828-454-1004 Phone; 828-454-1003 Fax

Standard Written Order

Patient's Name: _____ Patient's DOB: ____/____/____

Date of Order: ____/____/____

Post Mastectomy: Breast Cancer DX: _____

___ Mastectomy Bras with or without integrated form(s) qty: 4

___ Non Silicone Breast Forms qty: 2

___ Silicone Breast Prosthesis qty: 1 per affected side

___ Prosthetic Nipples qty: 2

Compression Garments: Lymphedema DX (circle one): I89.0 I97.2

___ Compression Bra day and night qty: 3

___ Truncal Compression Garment day and night qty: 3

___ Compression Sleeve day and night qty: 3 per affected side

___ Compression Glove qty: 3 per affected side

___ Compression Gauntlet qty: 3 per affected side

Other:

Ordering Provider's Name: _____

Provider's Signature: _____ Date: _____