



Patient Last Name: _____ Patient First Name: _____
 Fitter Last Name: _____ Fitter First Name: _____
 Fitter Title: _____ (example PT/OT/PTA)
 Date: _____



LEGASSIST - LOBULE COMPRESSION SYSTEM (LCS) Measure & Order Form

I have watched the online instruction video for the LegAssist™ custom garment. I have read and understand the written measuring instructions for the LegAssist™ custom garment. Photos have been emailed to: Sales@BiaCare.com

Orders will not be accepted without all three boxes being checked. Your assistance in this will help the patient receive a better product in less time.

PRODUCT OPTIONS

LEG: Right Left **FOAM:** Regular (flat foam) Advanced (WaveFoam™) **OPTIONAL:** Hip Attachment (additional charge)

Follow contour of limb on all measurements
(All measurements in cm)

- Lateral Length _____ **A₁**
- Medial Length _____ **B₁**
- Posterior Length _____ **C₁**
- Anterior Length _____ **D₁**

- Lateral Length _____ **A₂**
- Medial Length _____ **B₂**
- Posterior Length _____ **C₂**
- Anterior Length _____ **D₂**

