



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



Custom Made Circular Knitted Compression Stockings Order Form

Product / Brand	Quantity		Sand	Sun Bronze	Black	Amber	Navy
	left	right					
Seamless Soft 18-21 mmHg* (CCL 1)							
Seamless Soft 23-32 mmHg* (CCL 2)							
Seamless Soft 34-46 mmHg* (CCL 3)							
Bellavar™ *** 23-32 mmHg* (CCL 2)							
Bellavar™ *** 34-46 mmHg* (CCL 3)							

Basic Styles:

AD AF AG AG-T AG-HT AT

Options:

Closed toe Open toe Short foot (closed)

Special Options:

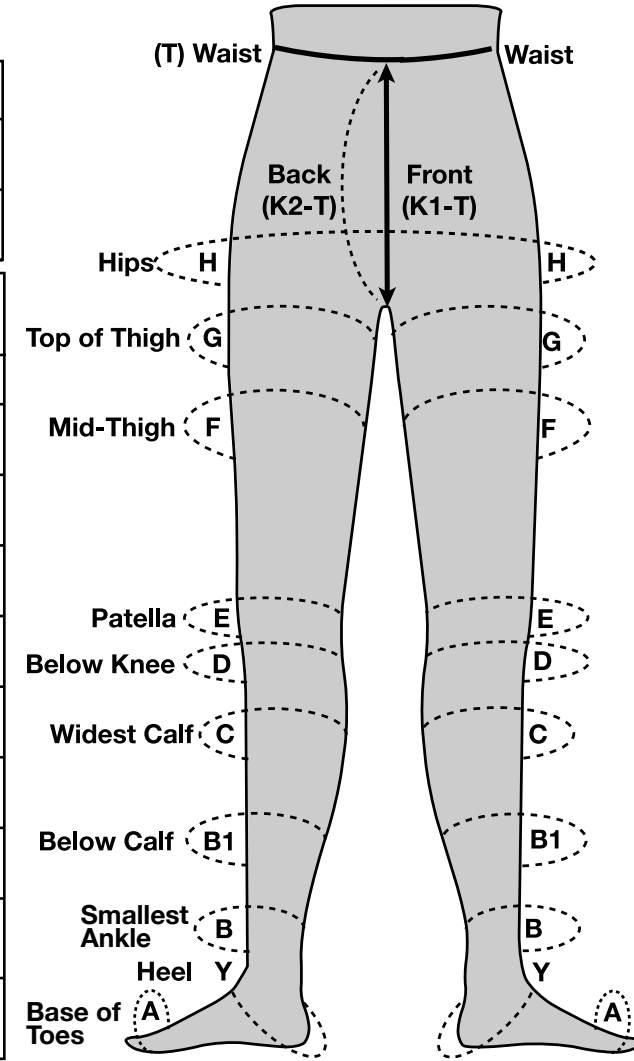
AD	<input type="checkbox"/> No Silicone	<input type="checkbox"/> Silicone dotted band 2.5 cm
	<input type="checkbox"/> Silicone dotted band 5 cm	<input type="checkbox"/> SoftFit™ (only in AD)

AF/AG No Silicone Silicone dotted band 5 cm
 Silicone lace band 6 cm Silicone Soft band 6 cm**

AT	<input type="checkbox"/> Maternity	<input type="checkbox"/> Fly for Men
	<input type="checkbox"/> Full compression	<input type="checkbox"/> Regular Adjustable Waist band
	<input type="checkbox"/> Waist band 2.5 cm**	<input type="checkbox"/> Waist band 5.0 cm**

Circum. (C)	Length (l)	Length (l)
cT	K2-T	lT
cH	K1-T	lH

Circumference (C)		Length (l): Taken from each landmark to floor.	
Left	Right	Left	Right
cG		lG	
cF		lF	
cE		lE	
cD		lD	
cC		lC	
cB1		lB1	
cB		lB	
cY		lA (medial)	
cA		lA (lateral)	



Foot length open toe *lA* _____ Foot length closed toe *lZ* _____
 (Not available in slant open or slant closed toe, only straight.)

Comments: _____

*Design Pressure **Not available in Full Compression or Bellavar ***Not available in Bellavar
 Take measurements on edema-free extremities only. All measurements must be recorded in cm.

THIS IS FOR THE INTENDED USE OF LUNA MEDICAL ONLY