Account Number: 1014233

Patient Last Name: _____ **Patient First Name:** _____

Fitter Last Name: _____ **Fitter First Name:** _____

Fitter Title: _____ (example PT/OT/PTA)

Date: _____

PRESCRIPTION ORDER FORM

Prescription Order must accompany all JOBST Elvarex, Elvarex Soft, Seamless Soft, and Bellavar orders.

For both Elvarex and Elvarex Soft a certified fitter number is required. Please call 1-800-537-1063 to learn more about our Certification Trainings.

1 DATE_____

- ☐ Original Order
- ☐ Reorder with Changes
- ☐ Exact Reorder

- ☐ Elvarex
- ☐ Elvarex Soft
- ☐ Seamless Soft
- ☐ Bellavar

2 GENDER

- ☐ Male
- ☐ Female

3 DIAGNOSIS Check Appropriate Box(es)

- ☐ Edema
- ☐ Lymphedema
- ☐ Orthostatic Hypotension
- ☐ Thrombotic Syndrome
- ☐ Arterial Insufficiency
- ☐ Stasis Ulcer
- ☐ Varicose Veins
- ☐ Venous Insufficiency
- ☐ Sclerotherapy/ Vein Ligation
- ☐ Other

4 Order Confirmation (FAX number or email address)

FAX #_____

Email Address_____

5 BSN medical Inc. File #

_____

Patient Name/ID Code

_____

Last Name First

Address _____

City/State/ Zip_____

Permanent ☐ Yes ☐ No

6 Prescribing Physician Name

_____

Specialty _____

Address _____

City _____ State _____

Fitter Number Required For All Elvarex and Elvarex Soft

7 Measured By _____

Custom Fitter #_____ Phone _____

Facility _____

8 BSN medical Inc. Account # _____

Ship To _____

Address _____

City _____ State _____

Zip Code _____ Country _____

Attention _____

9 BSN medical Inc. Account # _____

Bill To _____

Address _____

City _____ State _____

Zip Code _____ Country _____

Attention _____

If paying by credit card ☐ AMEX ☐ Mastercard ☐ Visa

Card # _____

Expiration Date _____

(Billing to facility only – no individual patient credit cards)

10 P.O. # _____

Luna Medical, Inc. · Specialists in Venous & Lymphatic Insufficiencies
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