



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 _____

- | | |
|---|--|
| <input type="checkbox"/> Original Order | <input type="checkbox"/> Elvarex |
| <input type="checkbox"/> Reorder with Changes | <input type="checkbox"/> Elvarex Soft |
| <input type="checkbox"/> Exact Reorder | <input type="checkbox"/> Seamless Soft |
| | <input type="checkbox"/> Bellavar |

2 GENDER

- Male
 Female

3 DIAGNOSIS Check Appropriate Box(es)

- | | |
|--|--|
| <input type="checkbox"/> Edema | <input type="checkbox"/> Stasis Ulcer |
| <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Orthostatic Hypotension | <input type="checkbox"/> Venous Insufficiency |
| <input type="checkbox"/> Thrombotic Syndrome | <input type="checkbox"/> Sclerotherapy/
Vein Ligation |
| <input type="checkbox"/> Arterial Insufficiency | <input type="checkbox"/> 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. # _____