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

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

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

**Date:** _____

# sigvaris

## Legassist Lobule Compression System (LCS)

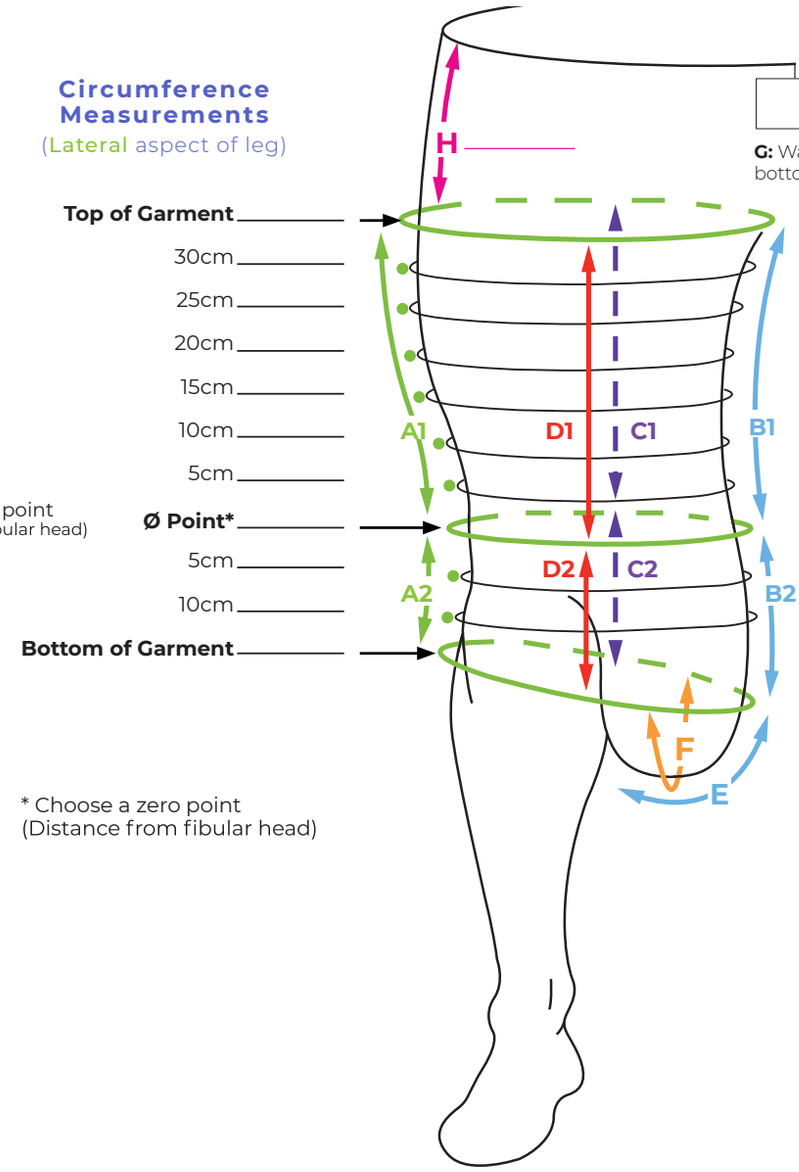
### Product Information

Product includes one Legassist Lobule Compression System (LCS).

| | | | |
|---|---|---|---|
| ☐ Right Leg<br>Size: ☐ Regular ☐ Super | ☐ Left Leg<br>Size: ☐ Regular ☐ Super | Foam<br>☐ Flat<br>☐ Wavefoam | Optional<br>☐ Hip Attachment |
| ☐ Right Leg<br>Size: ☐ Regular ☐ Super | ☐ Left Leg<br>Size: ☐ Regular ☐ Super | Foam<br>☐ Flat<br>☐ Wavefoam | Optional<br>☐ Hip Attachment |

**Note:** If the greatest circumference measurement is >90cm, order a Super.

### Circumference Measurements
(Lateral aspect of leg)




* Choose a zero point
(Distance from fibular head)

* Choose a zero point
(Distance from fibular head)

### Length Measurements

**Lateral**

A1 _____

A2 _____

**Medial**

B1 _____

B2 _____

**Posterior**

C1 _____

C2 _____

**Anterior**

D1 _____

D2 _____

**Transverse Lobule**
(Coronal Plane)

E _____

**Longitudinal Lobule**
(Sagittal Plane)

F _____

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