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

SIGVARIS

ArmAssist™
Measure & Order Form

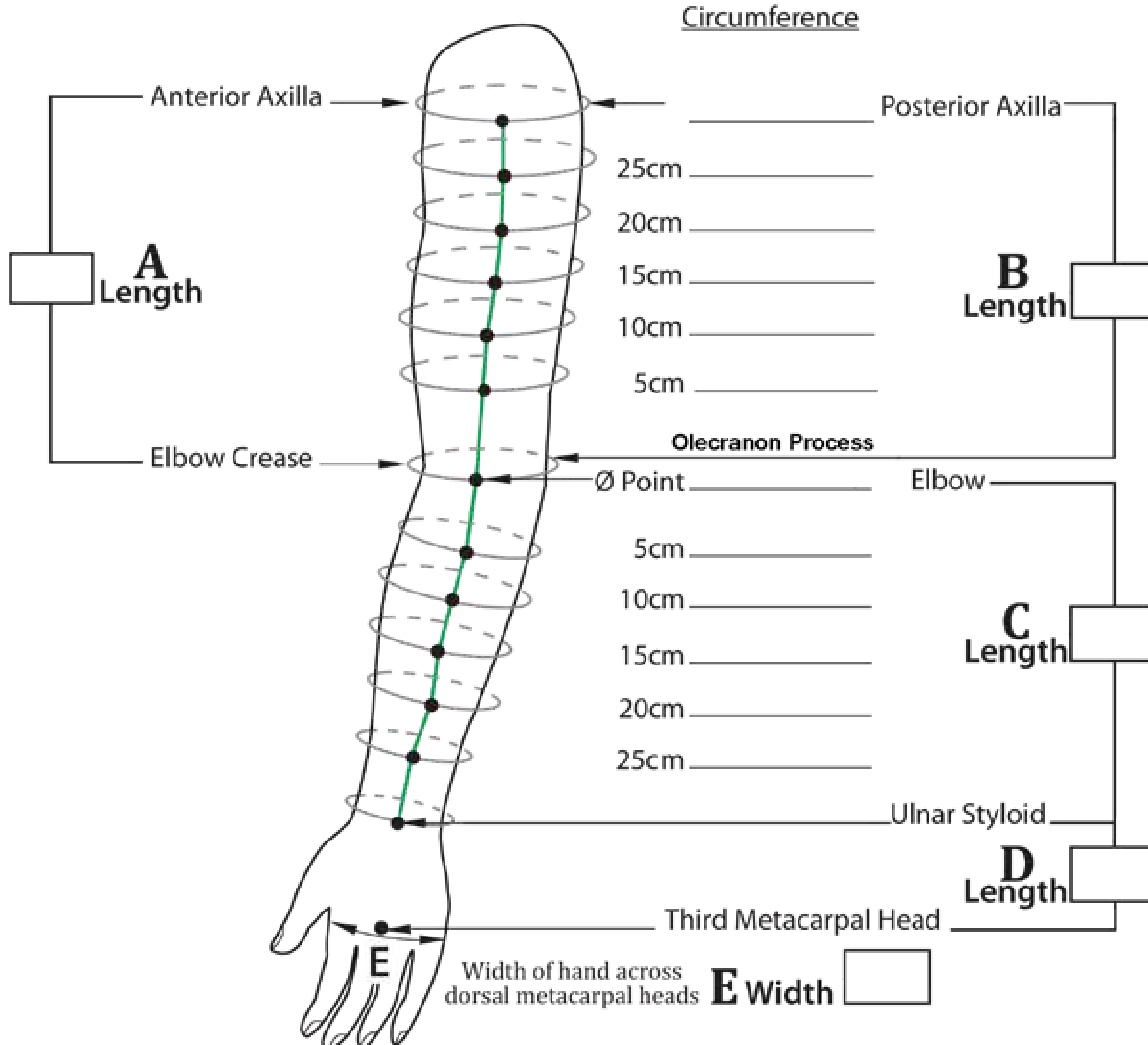
☐ I have watched the online instruction video for the ArmAssist™ custom garment.

☐ I have read and understand the written measuring instructions for the ArmAssist™ custom garment.

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

ARM: ☐ **Left** ☐ **Right** **FOAM:** ☐ **Regular** (flat foam) ☐ **Advanced** (WaveFoam™)



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