



Place Clinic Label Here

Patient Name: _____

Patient Address: _____

Patient Phone: _____

Patient D.O.B.: _____

(Where Device Will Be Delivered)

Pre-Op Consultation Date: _____

Surgery Date: _____

Insurance Provider: _____

Location of Surgery: _____

(For Billing Purposes)

Policy/Plan #: _____

Start Date of Therapy: _____

I.D./Certificate #: _____

Total Rental Price: _____

Therapy Duration: 10 Days 14 Days 21 Days Other: _____

Area of Therapy

Knee Shoulder Hip Back Ankle Wrist Other: _____

DVT Therapy (if DVT therapy is NOT required, please skip this section)

Calf Left Leg Calf Right Leg Calf Both Foot Left Leg Foot Right Leg Foot Both

Size of Disposable Therapy Wrap

Standard (most patients) Medium (BMI >40) Large (please consult Peak Medical)

Therapy Modality

(check box(es) in accordance with desired treatment)

Cooling Heating Compression If Cooling Only, Specify Temperature _____
(43°F to 50°F)

Treatment Recommended By: _____
(please print)

Office Contact Information: _____
(address/phone)

Surgeon/Physician Signature: _____

*Above signed agrees to therapy prescribed and to the therapy duration. If you require any further assistance or if you have inquiries please contact our Edmonton office @ 1-780-757-0040/TF 1-800-757-4635.