LYMPHEDEMA INSTITUTE OF OKLAHOMA

Patient Referral Form

REFERRING CLINIC

Clinic Name: _____

Office Contact Name: _____

Address: _____

Phone: _____ **Fax or Email:** _____

PATIENT DEMOGRAPHICS

If a patient demographic sheet is attached, you may skip the fields below.

***Patient Name:** _____ ***DOB:** _____

Address: _____

Primary Insurance: _____ **Group #:** _____

Secondary Insurance: _____ **Group #:** _____

REASON FOR REFERRAL

Patient is being referred for the fitting and supply of compression therapy garments and/or pneumatic compression devices.

CHECK ALL QUALIFYING DIAGNOSES THAT APPLY:

- ☐ **I89.0** Lymphedema, not elsewhere classified
- ☐ **I97.2** Post-mastectomy Lymphedema Syndrome
- ☐ **I97.89** Other postprocedural complications and disorders of the circulatory system, not elsewhere classified
- ☐ **Q82.0** Hereditary Lymphedema

CHECK ALL THAT APPLY:

- ☐ **ALL SERVICES** (Ask your rep for details)
- ☐ **NIGHTTIME COMPRESSION GARMENTS**
- ☐ **DAYTIME COMPRESSION GARMENTS**
  Calibrated and/or non-calibrated
- ☐ **PNEUMATIC COMPRESSION DEVICE**

CIRCLE AFFECTED AREAS:



PROVIDER CERTIFICATION & SIGNATURE

Provider Name: _____

Billing Address: _____

Phone: _____ **NPI:** _____

_____ _____

Provider Signature Date

ATTACHMENTS

- ☐ Patient Demographic Sheet
- ☐ Face-to-Face / Visit Notes
  - ☐ Qualifying Diagnosis
  - ☐ Location
- ☐ Conservative Therapy, when applicable

PHONE
405-449-4491

REFERRAL EMAIL
referrals@lymphedemainstitute.health

REFERRAL FAX
877-583-0878