Active Life
Orthotics • Prosthetics • Compression

Clinical History

Patient Name: ____

Lymphedema Treatment Program: ☐ Yes ☐ No   Hospital / Facility: ________________________

Diagnosis:
☐ I87.2 Venous Insufficiency (Chronic) (Peripheral)
☐ I89.0 Lymphedema, Not Classified Elsewhere

Affected Extremity: *Select All That Apply*
☐ Face/Neck ☐ Torso ☐ Right Arm ☐ Left Arm ☐ Genital
☐ Right Leg ☐ Left Leg ☐ Other: ____________________

History of Cellulitis or Infection: ☐ Yes ☐ No, If Yes Please Explain: ____________________________________

Primary Lymphedema:
☐ Milroy's Disease ☐ Lymphedema Praecox ☐ Lymphedema Tarda ☐ Klippel-Trenaunay Syndrome
☐ Other: ____

Secondary Lymphedema: Cancer
☐ Breast
☐ Melanoma
☐ Cervical
☐ Uterine
☐ Vulvar
☐ Prostate
☐ Head/Neck
☐ Other: _________________________

Breast Cancer Surgery: ☐ Lumpectomy ☐ Mastectomy

Cancer Surgery:
☐ Axillary Node Dissection ☐ Axillary Node Removal
☐ Groin Node Dissection ☐ Groin Node Removal

Surgery Month: _________________
Surgery Year: ___________________

☐ Radiation Therapy ☐ Chemo Therapy

Secondary Lymphedema: Venous Insufficiency
☐ Venous Ulcers
☐ Dermatitis
☐ Weeping Fluid
☐ Deep Vein Thrombosis (DVT)
☐ Post Phlebitic Syndrome
☐ Limb Heaviness
☐ Fibrosis
☐ Other: _________________________

Completed By: ____   Date: ____________

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Product Request

☐ I Don't Have a Preference, Please Choose for Me Based On the Information Presented.

Daytime Elastic Support

Brand
☐ Juzo ☐ WearEase
☐ Jobst ☐ Solaris
☐ Medi ☐ Lymphedivas
☐ Sigvaris ☐ Other: ___________

Garment Type
☐ Armsleeve ☐ Knee High Stocking
☐ Glove ☐ Thigh High Stocking
☐ Gauntlet ☐ Pantyhose
☐ Vest ☐ Legging / Capri
☐ Face / Neck ☐ Other: _______________

Daytime Non-Elastic Support

Brand
☐ Juzo ☐ BiaCare
☐ Jobst ☐ Farrow
☐ Medi ☐ CompreFlex
☐ Sigvaris ☐ Other: ___________

Garment Type
☐ Full Leg ☐ Full Arm
☐ Foot ☐ Glove
☐ Calf ☐ Gauntlet
☐ Knee ☐ Other: _______________
☐ Thigh

Nighttime Non-Elastic Support

Brand
☐ Tribute ☐ BiaCare
☐ Solaris ☐ Farrow
☐ Circaid ☐ Other: ___________
☐ JoviPak

Garment Type
☐ Full Leg ☐ Full Arm
☐ Foot ☐ Glove
☐ Calf ☐ Gauntlet
☐ Knee ☐ Torso
☐ Thigh ☐ Shorts / Capri
☐ Face / Neck ☐ Other: _______________

Compression Class
☐ 15-20 mmHg
☐ 20-30 mmHg
☐ 30-40 mmHg
☐ 40-50 mmHg

Garment Type
☐ Custom
☐ Ready to Wear

Measurements:

Completed By: ____ Date: ____________

Contact Us Today!
Phone: (818) 696 - 2019
Fax: (818) 243 - 1318
Email: compression@4activelife.com

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www.4activelife.com

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Patient Information

Please Have Form Completed by Patient to Insure Information is Correct

Patient Information

First Name: ____ Middle Initial: __________

Last Name: ____ DOB: _______________

Address: ____ Apt/Suite: ____________

City: ____ State: _________ ZIP: _____________

Phone: (_____) ___________________ Email: ____

Preferred Contact Method

☐ Phone ☐ Email

Ship Products To

☐ Medical Clinic ☐ Patient Residence

Physician Information

Referring Doctor: ____

Referring Doctor Phone Number: ____

Primary Insurance Information

Primary Insurance Name: _______________________________ ID #: __________________

Benefits/Eligibility Phone: _______________________________

Name of Insured: ____________________________________ DOB of Insured: __________

Primary Insurance: ☐ Medicare If So, ID #: _________________________

Completed By: ____ Date: __________

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Medical Records Release

By signing this form, I authorize you to release my confidential health information to the entity listed below. This includes a copy of my medical records, or a summary or narrative of my protected health information.

Patient Name: ____ Date of Birth: ________________

The information you may release subject to this signed release form is as follows:

☐ Complete Records

☐ Care Plan

☐ Measurements

☐ Progress Notes

☐ History and Physical

☐ Treatment Record

☐ Other: ________________________________

Release my protected health information to the following entity:

Active Life Inc.

1577 E Chevy Chase #210, Glendale, CA 91206

Phone: (818) 495-4610 | Fax: (818) 484-2812

Email: info@4activelife.com

Clinic Hours: Monday through Friday, 9 AM - 5 PM

Patient Signature: ____ Date: ____________

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