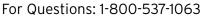
Prescription Order Form

All orders must be faxed or e-mailed. No phone orders accepted.

Fax: 1-800-835-4325

Email: Elvarex.Orders@bsnmedical.com

Prescription Order must accompany Elvarex Lower Ext. Order Form (50333) and Custom Seamless Soft & Bellavar Order form (60873)





1 DATE	6 Prescribing Physician Name
Original Order	
Reorder with Changes	Specialty
Order No. or Schema	Address
	CityState
2 GENDER	Zip Code
Male	Country
Female	
Female	7 Measured By
3 DIAGNOSIS Check Appropriate Box(es)	Custom Fitter # (if applicable)
Edema Stasis Ulcer	Phone
Lymphedema Varicose Veins	Facility
Orthostatic Venous	
Hypotension Insufficiency	0
Thrombotic Syndrome Sclerotherapy/	8 BSN medical Inc. Account #
Arterial Vein Ligation	Ship To
Insufficiency Other	Address
	City State Zip Code Country
7 • • • • • •	Attention
4 Order Confirmation (FAX number or email address)	,
FAX #	
Email Address	9 BSN medical Inc. Account #
	Bill To
5 BSN medical Inc. File #	Address
	City State Zip Code Country
Patient Name/ID Code	Attention
	If paying by credit card AMEX Mastercard Visa
Last Name First Address	
City/State/ Zip	Card #
Permanent Yes No	Expiration Date
	(Billing to facility only - no individual patient credit cards)
Date of Birth (mth/yr)	
Phone	10 P.O. #





