DVT PUMP ORDER FORM

Patient Name: _____

Patient Phone: _____

Surgery Date: _____

Surg Procedure: _____

MIDWEST COMPRESSION
Pneumatic Compression Devices

Fax Patient Demographic Sheet & Order

FAX: 800-886-4201

PH: 800-883-1549

Written Order / Prescription / DVT Risk Assessment

ICD Codes: _____ X _____ X _____ X _____ X _____

☐ DVT Prophylaxis Unit with Intermittent Limb Therapy (**RENTAL**)

Required: __ Days

☐ DVT Prophylaxis Unit with Intermittent Limb Therapy (**PURCHASE**)

☐ Other: _____

_____

DVT Risk Assessment

Total All Columns and Check Risk that Applies	EACH RISK FACTOR = 1 POINT	EACH RISK FACTOR = 3 POINTS
☐ **High Risk = 3 or more pts.** ☐ **Moderate Risk = 2 pts.**	__Age 40-59 years __History of prior major surgery (< 1 month) __Varicose veins __Swollen legs (current) __Obesity (BMI > 30) __Abnormal pulmonary function (COPD) __Medical patient currently at bed rest __Leg plaster cast or brace __Oral contraceptives or hormone replacement therapy __Pregnancy or postpartum (<1 month) __Use of tourniquet	__Age 75 years or older __Major surgery lasting 2-3 hours __BMI>50 (venous stasis syndrome) __History of SVT, DVT/PE __Family history of DVT/PE __Present cancer or chemotherapy
	EACH RISK FACTOR = 2 POINTS __Age 60-74 __Major surgery (>60 Minutes) __Arthroscopic surgery (>60 minutes) __Laparoscopic surgery (>60 minutes) __Previous malignancy __Morbid obesity (BMI>40) __General anesthesia >30 minutes	**EACH RISK FACTOR = 5 POINTS** __Elective major lower extremity arthroplasty __Hip, pelvis or leg fracture (<1 month) __Multiple trauma (<1 month) __Major surgery lasting over 3 hours **Safety Considerations (check off if applicable)** __ Patient has severe peripheral arterial disease __ Patient has congestive heart failure __ Patient has an acute superficial DVT
__ High risk of bleeding	**Other Risk Factors = 1 Point** ___ Current smoker History of hypercoagulability ___ Other: _____	

I have assessed that this patient is at risk of developing DVT. Because of this risk and limited ambulation, I am prescribing a DVT prevention therapy using a pneumatic compression device. In my opinion this is medically necessary and in accordance with standards of medical practice and appropriate treatment for this patient. I certify that the above prescribed medical equipment is medically indicated and in my opinion reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition. **Do not substitute.**

Physician's Original Signature: _____ **Date:** _____

Physician's Name: _____ **Physician's NPI #** _____

Clinic Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____