



**Health**  
South Western Sydney  
Local Health District

SURNAME		MRN
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		

**COMMUNITY HEALTH SERVICES**

**AUTHORITY TO APPLY COMPRESSION**

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

**GRADUATED COMPRESSION THERAPY**

Indications:

Venous     Mixed     Lymphoedema     Anti-embolic    Other: \_\_\_\_\_

Application Site	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Right Leg
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Ankle Brachial Pressure Index (ABPI)	Result:	Result:
	Date:	Date:

Other investigations conducted		

Level of Graduated Compression Therapy	<input type="checkbox"/> Class I (18-22 mmHg)	<input type="checkbox"/> Class I (18-22 mmHg)
	<input type="checkbox"/> Class II (20-30mm Hg)	<input type="checkbox"/> Class II (20-30mm Hg)
	<input type="checkbox"/> Class III (30-40mmHg)	<input type="checkbox"/> Class III (30-40mmHg)
	<input type="checkbox"/> Class IV (40-50mmHg)	<input type="checkbox"/> Class IV (40-50mmHg)
	<input type="checkbox"/> Anti-embolic stocking	<input type="checkbox"/> Anti-embolic stocking

Type of Graduated Compression Therapy	<input type="checkbox"/> Graduated shaped tubigrip	<input type="checkbox"/> Graduated shaped tubigrip
	<input type="checkbox"/> 2 layer long stretch bandage (eg. Surepress)	<input type="checkbox"/> 2 layer long stretch bandage (eg. Surepress)
	<input type="checkbox"/> 2 layer short stretch bandage (eg. Lastolan, Comprilan)	<input type="checkbox"/> 2 layer short stretch bandage (eg. Lastolan, Comprilan)
	<input type="checkbox"/> 2 layer (eg. Proguide)	<input type="checkbox"/> 2 layer (eg. Proguide)
	<input type="checkbox"/> 4 layer (eg. Veno4/Profore)	<input type="checkbox"/> 4 layer (eg. Veno4/Profore)
	<input type="checkbox"/> Lymphoedema bandaging	<input type="checkbox"/> Lymphoedema bandaging
	<input type="checkbox"/> Stocking/Garment	<input type="checkbox"/> Stocking/Garment

Other Sites (eg lymphoedema of arm - post surgical/oncological): \_\_\_\_\_

Name of Vascular Specialist: \_\_\_\_\_ Telephone: \_\_\_\_\_

**AUTHORISING CLINICIAN (Medical Officer/General Practitioner)**

Name: \_\_\_\_\_ Signature \_\_\_\_\_

Designation: \_\_\_\_\_ Date: \_\_\_\_\_ Telephone: \_\_\_\_\_

BINDING MARGIN - NO WRITING

FILE IN CLINICAL RECORD

ID 6080847 Oct 13

**AUTHORITY TO APPLY COMPRESSION**

**AMR 024.001**