MEDICAL Z®

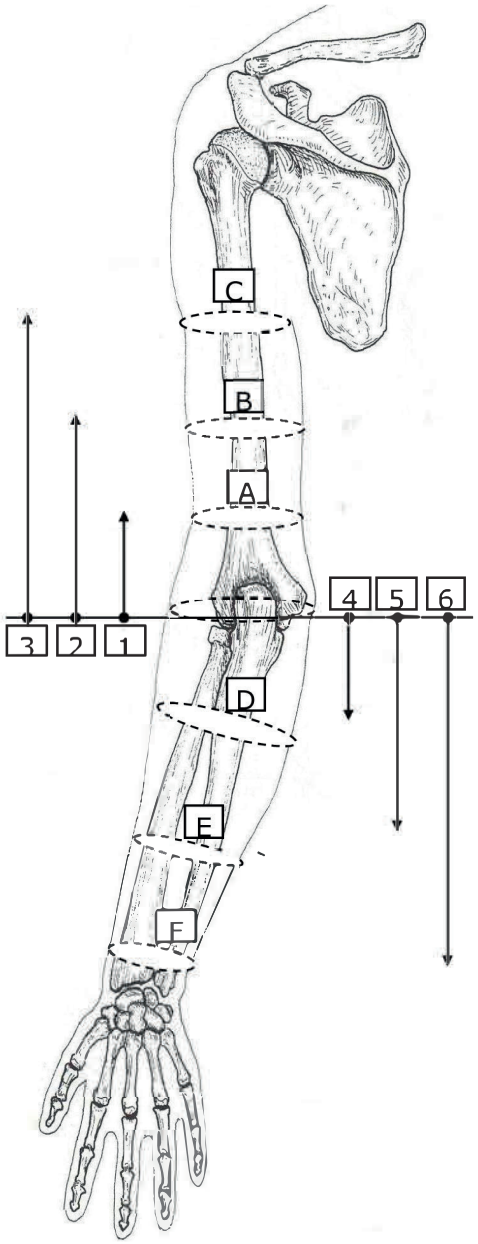
From: _____
Date: _____/_____/_____
Patient: _____
Date of Birth: _____/_____/_____
Sex: *(Circle One)* Male ○ Female ○
Organization File No_____
Medical Z File No._____
Measured By _____/_____

Comments: _____

CUSTOM COMPRESSION GARMENTS FOR

☐ **LYMPHEDEMA**
☐ **VASCULAR SUPPORT**

Posterior View
Left Arm



(all lengths are taken from Elbow)

☐ **Coolmax**

Right Arm Above Elbow

	Lengths		Circum.
1		A	
2		B	
3		C	

Left Arm Above Elbow

	Lengths		Circum.
1		A	
2		B	
3		C	

Right Elbow Circum. _____

Left Elbow Circum. _____

Right Arm Below Elbow

	Lengths		Circum.
4		D	
5		E	
6		F	

Left Arm Below Elbow

	Lengths		Circum.
4		D	
5		E	
6		F	

Styles

☐ Axilla to Elbow
☐ Elbow to Wrist
☐ Axilla to Wrist

☐ **Color**

All measurements are in centimeters to the nearest 10th