

ORDER FORM

Date: _____

Patient Details

Patient Type: New Patient Existing Patient Quote Only

First Name: _____ Last Name: _____

Preferred Pronouns: She/Her He/Him They/Them Other (Please specify): _____

Anatomy: Female Male Date of Birth: _____ Age: _____

Address: _____

Phone: _____ Email Address: _____

Carer Details: Name: _____ Phone: _____ Relationship: _____

Diagnosis: _____

Referrer Details

Hospital/Private Practice: _____

Doctor/Surgeon: _____ Provider No.: _____

Therapist: _____ Provider No.: _____

Invoice to

Hospital/Private Practice Name: _____ Order Number: _____ Patient

Insurance Company: _____ Claim No.: _____

Case Manager: _____ Phone: _____ Email: _____

Employer Name: _____ Date of Injury: _____

Credit Card Details Name of Card Holder: _____

Card Number: --- Expiry Date (MM/YY): _____ CVC: _____

Deliver to

Hospital Address: _____

Private Practice _____

Patient As Above Other (Please specify): _____

Clinical Justification/Garment Description

Patient Name:

Date:

Therapist Name:

DOB:

Age:

Custom Made Scrotal Support

Provides support and patient comfort by alleviating heavy sensation and is comfortable to wear.

Order Quantity

Colours

Garment 1 Colour

Beige Black

Garment 2 Colour

Beige Black



Note - this garment does not apply circumferential pressure.

Measurements (in centimetres)

Waist Circumference  cm

Select Scrotum Size

Small (Orange Size)

Medium (Rock Melon Size)

Large (Watermelon Size)

Comments