

Lymphedema Assessment

Chart # 8583

Assessment Date: 8/2/2021

Patient Name: Mary Boms

DOB: 9/6/1958

Diagnosis (check all that apply)

- ☐ I89.0 Secondary Lymphedema
☐ Q82.0 Hereditary Lymphedema
☐ I97.2 Post Mastectomy Lymphedema
☒ Lipedema
☐ I87.2 Chronic Venous Insufficiency

Pneumatic Compression Recommendation

Treatment Pressure: 40 mmHg
 Frequency per day: 1
 Duration: 1 hours
 Upper Extremities: ☒ Left Arm ☒ Right Arm ☐ Chest
 Lower Extremities: ☒ Left Leg ☒ Right Leg ☐ Trunk

Physical Exam

Symptoms / Skin condition (check all that apply)

- ☐ Edema ☐ Wounds ☐ Weeping ☐ Blisters ☒ Heaviness ☒ Pain ☐ Hyperkeratosis ☒ Hyperplasia ☒ Fibrosis
☐ Hyperpigmentation ☐ Elephantiasis ☐ Lymphorrhea ☐ Pappilomastosis cutis lymphostatica (pappiloma)

Severity (check all that apply)

- ☐ Brawny ☒ Non-Pitting ☐ Fibrotic ☐ Pitting ☐ +1 ☐ +2 ☐ +3 ☐ +4 ☐ Stage I ☐ Stage II ☐ Stage III ☐ Other _____

Areas Affected (check all that apply)

- ☒ Right Lower Extremity ☒ Left Lower Extremity ☐ Abdomen ☐ Trunk ☐ Genitals
☒ Right Upper Extremity ☒ Left Upper Extremity ☐ Chest ☐ Other _____

Treatments to Date (check all that apply)

Start of treatment 2018; just restarted

- ☒ Elevation of extremity
☒ Exercise / ROM / calf pump
☒ Complete Decongestive Therapy / MLD
☒ Compression / type Over the counter
☐ Use of a Basic Pneumatic Compression Pump

Outcome of Treatments

Do significant symptoms remain? ☒ Y ☐ N

Treatment Plan (check all that apply)

- ☒ Compression, type Biaflex or CF Socks
☒ Regular elevation of extremity
☒ Regular exercise, perform ROM / calf pump exercise
☒ Other MLD
☒ Lympha Press® (requires a failed 4-week trial of conservative treatments)

Prescribing Clinician Signature (if applicable)

[Signature]

Assessment Completed by: Karen L Herbst

Signature: [Signature]



FAX 888-475-3508

COMPRESSION/LYMPHEDEMA PUMP PRESCRIPTION FORM

Patient Name: DOB: Mary Berns 9/6/1958

Patient Phone #: (physician) Karen L. Herbst, MD, PhD
320-492-7404

SEGMENTAL APPLIANCE: LEGS: ☒ LT ☒ RT ARMS: ☒ LT ☒ RT

Special request:

Treatment: Pressures _____ FREQ _____ /DAY _____ MIN Length of Necessity: 99 mths
Default: 40mmHg, TID/BID, 60 min (99= purchase)

PLEASE CHECK ANY CONDITIONS THAT MAY APPLY TO THE PATIENT

Diagnosis:

☐ I97.2 POST MASTECTOMY SYNDROME ---Date of Surgery:
____/____/____

☐ Q82.0 PRIMARY LYMPHEDEMA

☒ I89.0 OTHER CAUSES OF SECONDARY LYMPHEDEMA

☐ VENOUS INSUFFICIENCY causing Secondary Lymphedema

☐ TUMOR(S) OBSTRUCTING LYMPHATIC FLOW

☐ SCARRING of the lymph channels – cellulitis, lymphangitis

☐ CANCER SURGERY or radiation causing Lymphedema

☒ OTHER Lymphedema secondary to lipedema

☐ I87.2 CHRONIC VENOUS INSUFFICIENCY (with or without wounds) Possible

PRESCRIBING PHYSICIAN: (please print) LAST ___ Herbst FIRST ___ Karen

NPI #: 1114977840 PHONE 310-882-5454 FAX 310-747-5908

PHYSICIAN SIGNATURE _____

DATE 8/21/2021