

Name / BSN File # _____ DOB _____ Date _____
 Address _____ Gender M F
 City/State/Zip _____ Diagnosis _____

PO# Doctor/Address _____

Original Order Reorder w Changes

Exact Reorder

Schema # _____

City/State/Zip _____

Fitter Name _____ Fitter # _____ Fitter Phone _____

Fitter Facility _____ Email _____

Ship To Acct # _____ Acct Name _____

Address _____ City _____ State _____ Zip _____

Email _____ Phone _____ Fax _____

Bill To Acct # _____ Acct Name _____

Address _____ City _____ State _____ Zip _____

Email _____ Phone _____ Fax _____

Confirmation Fax # _____

Email _____

By choosing communication via email (above), I acknowledge that Personal Health Information associated with this purchase may be transmitted from BSN in a non-encrypted manner.

Last 4 digits of credit card on file OR Exp. _____

New card - call to provide credit card # Billing Zip _____

Name on CC _____

- Elvarex*****
- Cherry
 - Navy
 - Beige
 - Black
 - Honey
 - Cranberry
 - Hazelnut (CCL 1, 2 only)

- Elvarex**® Soft (N/A IN CCL3)
- Beige
 - Black
 - Honey
 - Cranberry
 - Cherry
 - Navy
 - Grey
 - Cocoa

Quantity/Class	CCL1 (15-21mmHg*)	CCL2 (23-32mmHg*)	CCL2F† (23-32mmHg*)
Left			
Right			

Style (AG AH AND CH NOT AVAILABLE IN SOFT)

- CG Sleeve
- CH Sleeve & shoulder cap††††
- AG Sleeve & hand attachment††††
- AH Sleeve, hand attachment & shoulder cap††††

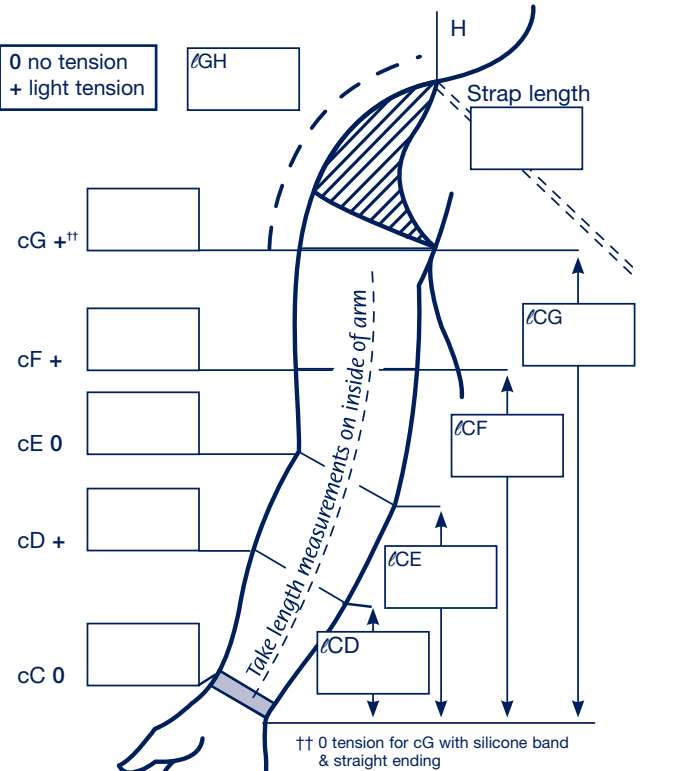
Shoulder Cap Options (CH and AH) (Elvarex only)

- Shoulder Strap
- Bra loop with Velcro _____ cm (Bra Strap width)

Elbow Options

- Pocket Inside Elbow (Not available with Elbow Comfort)
- Elbow Comfort† (CCL 2 only)
- Lining (Pocket all sides closed)

Silicone Band	On Top	Inside	Inside ¾
2.5 cm			
SoftFit (C-G only)			
5 cm (Elvarex® Soft = On Top only)			
Zipper†	Inside	Outside	On Top
C-E only			
E-G only			



* Design Pressure *** Not available in Elvarex Soft † Only available in Elvarex
 **CAUTION: This product contains natural rubber latex which may cause allergic reactions.

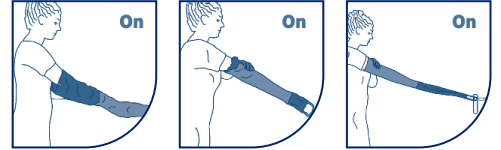
NOTE: Garments ordered in black and beige have an estimated arrival time of 4-5 business days from the date submitted. All other colors have an estimated arrival time of 7-10 business days from the date submitted.

F _____

Arion Easy-Slide Arm

- The user-friendly application aid makes putting on compression arm sleeves quick and easy
- A straightforward donning method in combination with the application aid

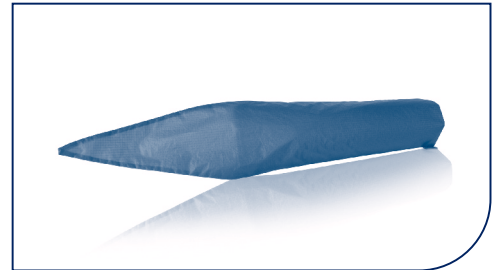
Size	Circumference of widest part of the arm	BNR	UOM / Box	Order Qty
Medium	14.5" - 15.1" (37 - 38.5cm)	7966102	1	
Large	15.3" - 16.1" (39 - 41cm)	7510001	1	



Arion Easy-Slide Kids

- Specifically designed to alleviate the problems experienced when donning arm and leg sleeves for children

Size	Age	Length	BNR	UOM / Box	Order Qty
X-Small	0-3 yrs	11.6" (29.5cm)	7957108	1	
Small	3-6 yrs	15.5" (39.5cm)	7957109	1	



Dycem® Non-Slip Material*

- Improves grip
- Provides stability
- Helps with easier donning of a JOBST® garment

* Caution: This product contains natural rubber latex which may cause allergic reactions.

Size	BNR	UOM / Box	Order Qty
One size	7763600	1	

Dycem® is a registered trademark of Dycem Ltd.



JOBST® Donning Gloves*

- Help to create friction and provide grip
- Help to evenly distribute the fabric on the leg

* Caution: This product contains natural rubber latex which may cause allergic reactions.

Size	BNR	UOM / Box	Order Qty
Small	131202	1 pair	
Medium	131203	1 pair	





JoViPak

Arm Sleeves Custom

Email Form to Sales@acols.com FAX: 772-589-0306

Patient Name: _____

Previous Patient? Yes No

Height: _____ Weight: _____ Birthdate: _____

Primary (congenital) or Secondary Lymphedema
(if no selection is made, JoViPak will default to Secondary Lymphedema)

PAYMENT INFORMATION

Account # <input type="checkbox"/> Bill to Account	Date
<input type="checkbox"/> Charge Credit Card <input type="text"/> <input type="text"/> Card Exp. Date	PO #
Card #	Fax Confirmation #
Name on Card	Email Confirmation

BILLING ADDRESS

Business Name
Address
Attention
City State
Phone Zip

SHIPPING ADDRESS

Same as Billing Address

Business Name
Address
Attention
City State
Phone Zip

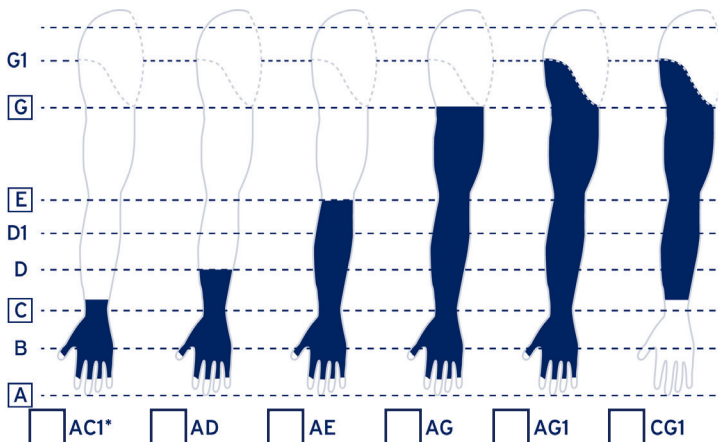
ORDER SPECIFICATIONS

Quote Only Quote & Proceed

RUSH OPTION Additional 25% charge for 3 business day production period

SHIPPING Shipping rates may vary, depending on services requested and/or rates charged by carrier

FedEx® (2 day shipping) Check if shipping to a residence \$10.00 to business addresses; \$13.25 to residential addresses (Additional services may be available; contact JoViPak to discuss.)



Polartec® Power Dry® Colors	
<input type="checkbox"/> Black	<input type="checkbox"/> Buff
<input type="checkbox"/> Navy Blue	<input type="checkbox"/> Pink
<input type="checkbox"/> Plum	<input type="checkbox"/> Royal Blue
<input type="checkbox"/> Stainless Steel	

Organic Cotton Colors	
<input type="checkbox"/> Black	<input type="checkbox"/> Ivory
<input type="checkbox"/> Royal Blue	

SUPER Powernet Colors (InnaSleeve)	
<input type="checkbox"/> Black Cotton/Black SUPER Powernet	<input type="checkbox"/> Ivory Cotton/ Buff SUPER Powernet

*To only be worn with a CG1

Fitter/Therapist Name: _____ Phone: _____ Email: _____

Questions? Call us at 800-863-5935 Ext #1 or Email Sales@acols.com



JOBST®, an Essity brand



/JOBSTUSA



@JOBST_USA



@JOBSTforUSA



jobst-usa.com

Lymphedema Store
11632 High St Ste A Sebastian Florida 32958
Phone: 800-863-5935 or Fax: 772-589-0306

63677 R3 ©2022 BSN Medical Inc. B22



Arm Sleeves Custom

Email Form to Sales@acols.com FAX: 772-589-0306

JoViPak

Measure extended arm in relaxed position, palm up

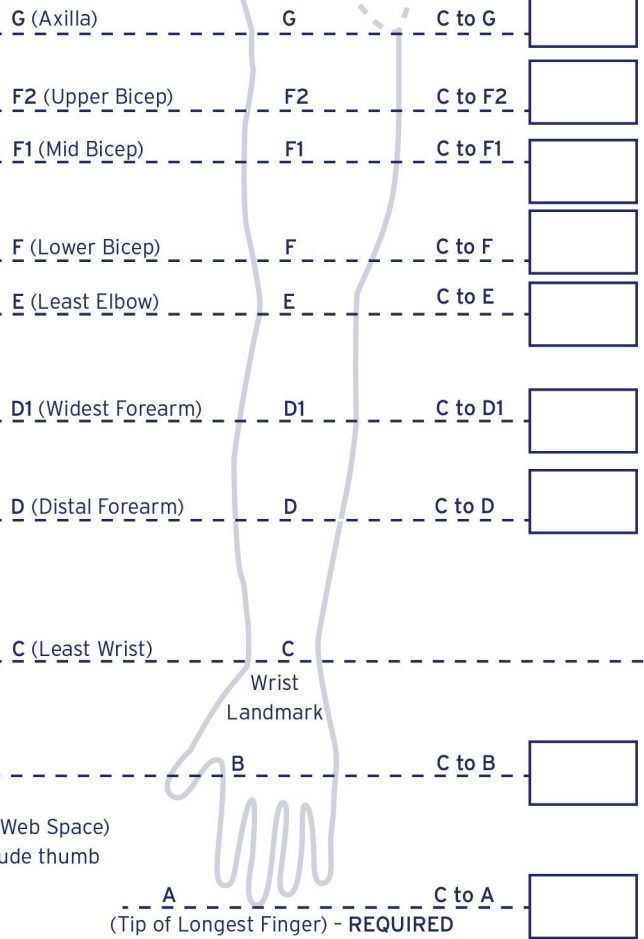
Please record measurements in centimeters.

G1 Lateral Rise Options:

- 6.35 cm (default)
- 10.15 cm

Circumference

Left	Right
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>



Pictures are needed if the patient has lobules, is over-sized or has some other issue. Please send pictures (no patient faces) to info.jovipak@essity.com.

Styles

- Standard Arm Sleeve (AC1 to AG1)
- InnaSleeve (AG - Organic Cotton with attached SUPER Powernet JoViJacket)

No Charge Options

- Slimline (more channels and less foam than standard channelling)
- Cover to middle of finger
- Cover to base of finger
- Cover fingers completely
- 2 Blend Foam (Low ILD)

Additional Charge Options

- JoViJacket Black White (JoViJackets are required to be worn with your JoVi foam garment to ensure maximum fit and effectiveness)
- Stitched Finger Glove
- Pad - Dorsum (sewn in; provides additional pressure on dorsum)
- Palm Pad (sewn in; equalizes pressure in palm area)
- Two Piece Arm Sleeve (AG1 or AG - separate hand; JoViJacket will match garment)
- Zipper - dorsum to mid-forearm
- Zipper - elbow to axilla
- Zipper - wrist to elbow
- Dycem® - donning aid
- Arion Easy-Slide - donning aid (for garments without a Stitched Finger Glove)
- Prepaid Reduction Option

Dycem® is a registered trademark of Dycem Ltd.



Arion Easy-Slide Arm ^{on}

- The user-friendly application aid makes putting on compression arm sleeves quick and easy
- A straightforward donning method in combination with the application aid



Size	Circumference of widest part of the arm	BNR	UOM / Box	Order Qty.
Medium	14.5"-15.1" (37-38.5cm)	7966102	1	
Large	15.3"-16.1" (39-41cm)	7510001	1	

Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

Questions? Call us at 800-863-5935 Ext #1 or Email Sales@acols.com

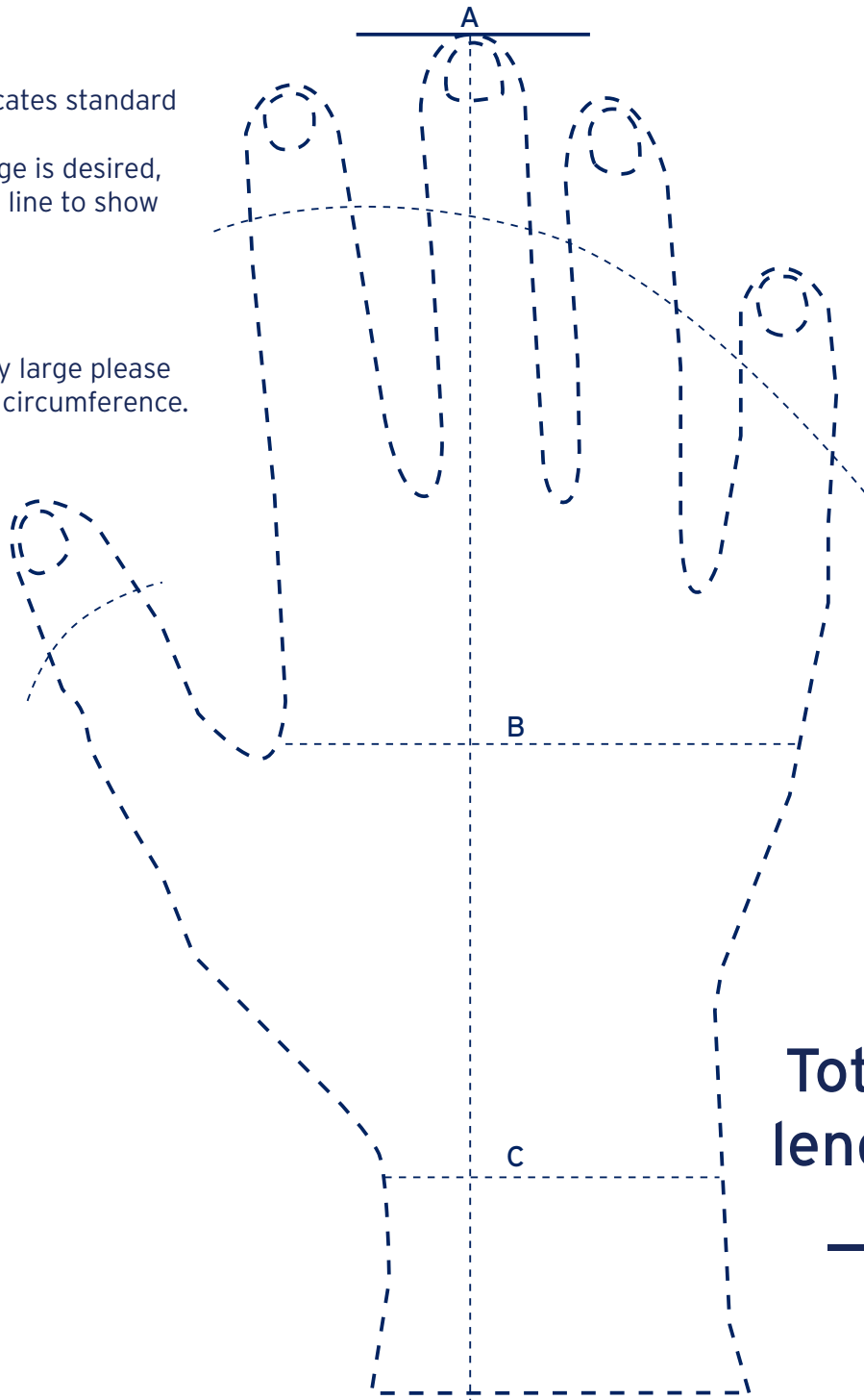
Patient Name or Reference # _____

Custom Hand Tracing Right Hand

Place hand flat, directly over this guide, palm down, with wrist flexion crease over the C landmark. Use a black pen to trace around the hand and each finger.

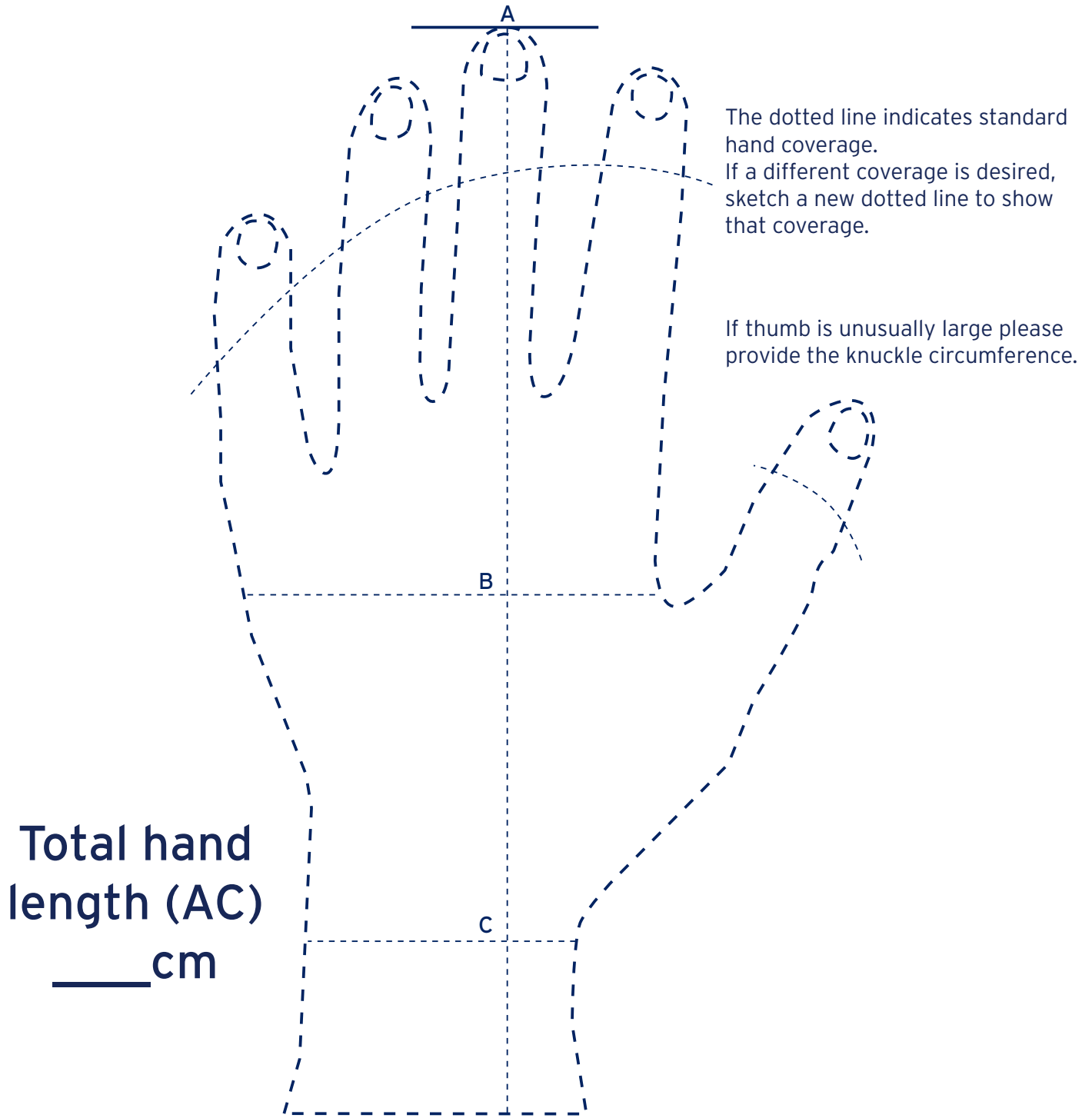
The dotted line indicates standard hand coverage.
If a different coverage is desired, sketch a new dotted line to show that coverage.

If thumb is unusually large please provide the knuckle circumference.



Custom Hand Tracing Left Hand

Place hand flat, directly over this guide, palm down, with wrist flexion crease over the C landmark. Use a black pen to trace around the hand and each finger.





JOBST® Custom™ Seamed Order Form

1 DATE: _____ <input type="checkbox"/> ORIGINAL ORDER <input type="checkbox"/> REORDER <input type="checkbox"/> QUOTE ONLY RUSH Order with charge: <input type="checkbox"/> yes	2 GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <hr/> 3 SEVERITY <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE	4 DIAGNOSIS: Please Check Appropriate Box(es) <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Edema</td> <td><input type="checkbox"/> Venous Ulcer</td> </tr> <tr> <td><input type="checkbox"/> Lymphedema</td> <td><input type="checkbox"/> Varicose Veins</td> </tr> <tr> <td><input type="checkbox"/> Orthostatic Hypotension</td> <td><input type="checkbox"/> Venous Insufficiency</td> </tr> <tr> <td><input type="checkbox"/> Thrombotic Syndrome</td> <td><input type="checkbox"/> Arterial Insufficiency</td> </tr> <tr> <td><input type="checkbox"/> Sclerotherapy/ Vein Ligation</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other: List _____</td> <td></td> </tr> </table> <hr/> 5 <input type="checkbox"/> 15-20 mmHg <input type="checkbox"/> 40-50 mmHg <input type="checkbox"/> 20-30 mmHg <input type="checkbox"/> Other: _____ <input type="checkbox"/> 30-40 mmHg	<input type="checkbox"/> Edema	<input type="checkbox"/> Venous Ulcer	<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Orthostatic Hypotension	<input type="checkbox"/> Venous Insufficiency	<input type="checkbox"/> Thrombotic Syndrome	<input type="checkbox"/> Arterial Insufficiency	<input type="checkbox"/> Sclerotherapy/ Vein Ligation		<input type="checkbox"/> Other: List _____	
<input type="checkbox"/> Edema	<input type="checkbox"/> Venous Ulcer													
<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Varicose Veins													
<input type="checkbox"/> Orthostatic Hypotension	<input type="checkbox"/> Venous Insufficiency													
<input type="checkbox"/> Thrombotic Syndrome	<input type="checkbox"/> Arterial Insufficiency													
<input type="checkbox"/> Sclerotherapy/ Vein Ligation														
<input type="checkbox"/> Other: List _____														
6 <div style="text-align: right;">File Number _____</div> PATIENT NAME or ID# _____ Date of Birth _____ / ____ / ____ <small style="margin-left: 100px;">Last Name First</small> <small style="margin-left: 150px;">Month</small> <small style="margin-left: 10px;">Year</small> Address _____ _____ _____ Phone # () _____														
7 PRESCRIBER _____ Phone # _____ Address _____ Specialty _____ _____ _____														
8 DEALER / CLINIC / HOSPITAL _____ Phone # () _____ Facility Account # _____ Order confirmation: Fax No. _____ or E-Mail address _____ Measured By: _____ Fitter # _____														
9 SHIP TO _____ Facility Account # _____ Address _____ _____ _____ Attention _____														
10 BILL TO _____ Facility Account # _____ Address _____ <input type="checkbox"/> Prepaid _____ Same as <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Invoice _____ Attention _____ P.O. No. _____														
11 <input type="checkbox"/> VISA <input type="checkbox"/> MC <input type="checkbox"/> AMEX Expiration Date _____ Auth.# _____ Card Number _____ Card Name _____														

Federal Law (USA) restricts the device to the sale by or on the order of a physician.

CUSTOM SEAMED - ARM

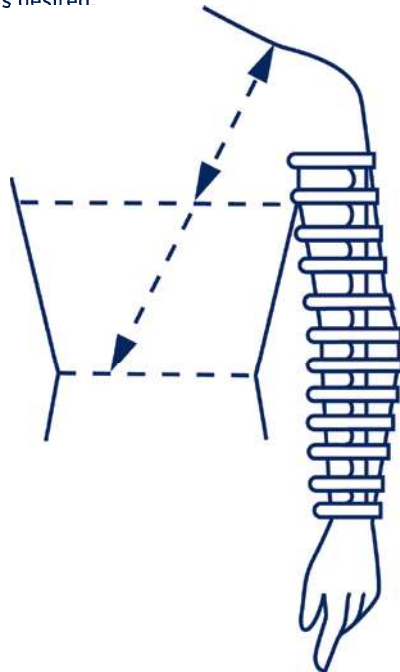
PATIENT'S NAME and/or ID # _____

12 STYLES / OPTIONS				
CAT. NO.	STYLES	QTY. LEFT	QTY. RIGHT	PRICE EACH
100505	Detachable Gauntlet (metacarpals to wrist)			
100515	Half Sleeve (wrist to elbow)			
100516	Half Sleeve & Gauntlet (metacarpals to elbow)			
101155	Half Sleeve (elbow to axilla)			
100501	Arm Sleeve (wrist to axilla)			
100503	Arm Sleeve with Attached Shoulder Flap			
100502	Arm Sleeve & Gauntlet (metacarpals to axilla)			
100504	Arm Sleeve, Gauntlet and Shoulder Flap			
101140	Arm Stump to Axilla			
Options				
101164	Zippers (see box 14)			
101167	Lining Inside Elbow			
101168	Lining Full Elbow			
101172	Adjustable Shoulder Flap (see box 15)			
101176	Contracture Seam			
110118	1" Silicone Band			
100160	2" Silicone Band			
100150	Beige			
100158	Black			

TOTAL \$0.00

Standard length zipper is full length. If shorter zipper is desired please indicate length from wrist.

14 ZIPPER OPTIONS				
	LOCATION MARK (D)		LENGTH IN INCHES	
	LEFT	RIGHT	LEFT	RIGHT
LATERAL (outside) ASPECT (standard)				
MEDIAL (ulner) ASPECT (inside)				
POSTERIOR (back of hand)				
ANTERIOR (palm of hand)				



15 SHOULDER FLAP			
LEFT		RIGHT	

Length diagonally from top of shoulder to waist or below breast.

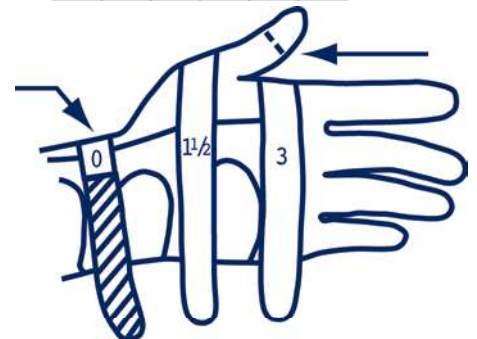
--	--	--

Give circumference for adjustable flap at waist or below breast.

* 13 ARM CIRCUMFERENCE

PLEATS	WRIST TAPE#		PLEATS
	LEFT	RIGHT	
		-6	
		-4 1/2	
		-3	
		-1 1/2	
		0	
		+1 1/2	
		+3	
		+4 1/2	
		+6	
		+7 1/2	
		ELBOW 9	
		+10 1/2	
		+12	
		+13 1/2	
		+15	
		+16 1/2	
		+18	
		+19 1/2	
		AXILLA	

16 THUMB CIRCUMFERENCE			
LEFT		RIGHT	



*Start measuring arm from elbow to wrist then elbow to Axilla

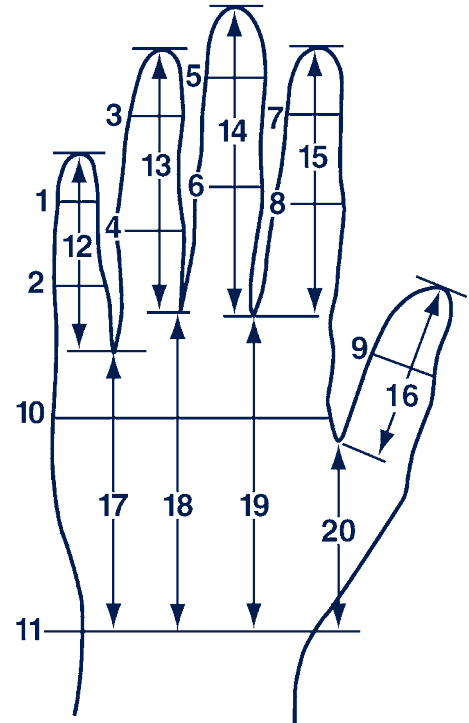
CUSTOM SEAMED - HAND

PATIENT'S NAME and/or ID # _____

17 STYLES / OPTIONS				
CAT. NO.	STYLES	QTY. LEFT	QTY. RIGHT	PRICE EACH
100532	Glove to Axilla			
100533	Glove to Axilla with Shoulder Flap			
100534	Glove to Elbow			
100535	Glove to Wrist			
100536	Interdigital Web Spacer (to be work over glove)			
100537	Mitten to Wrist			
Options				
101164	Zippers (see box 19)			
101169	Slant Inserts			
101167	Lining inside Elbow			
101168	Elbow lining (full)			
100021	Reinforced Palm or Dorsum			
100150	Beige			
100158	Black			

TOTAL \$0.00

Should be taken from outline drawings unless fingers are contracted.



* **18 LENGTHS (HAND OUTLINE REQUIRED)**

For Open Tip, give finished length desired	IF OPEN	LEFT	RIGHT	IF OPEN
Little finger to web between little finger and ring finger				
Ring finger to web between ring and middle fingers				
Middle finger to web between middle and index fingers				
Index finger and web between middle and index fingers				
thumb to thumb web				
Wrist to web between middle and ring fingers				
Wrist to web between middle and ring fingers				
Wrist to web between index and middle fingers				
Wrist to thumb web				

19 ZIPPER OPTIONS (mark ✓)

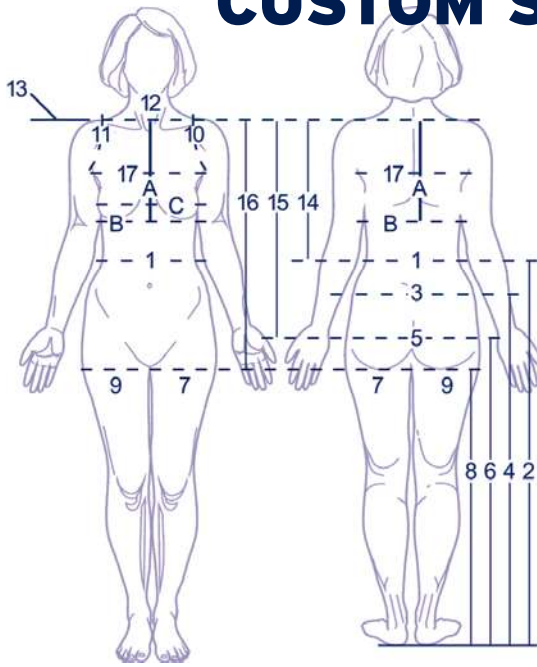
	LEFT	RIGHT
DORSAL (posterior) ASPECT (standard)		
ULNAR (little finger) (standard)		
PALMAR (anterior)		

20 CIRCUMFERENCES

	LEFT	RIGHT
Little finger DIP		
Little finger PIP		
Ring finger DIP		
Ring finger PIP		
Middle finger DIP		
Middle finger PIP		
Index finger DIP		
Index finger PIP		
Thumb		
Palm		
Wrist		
1 1/2" beyond Wrist		
3" beyond Wrist		

* Hand outlines must have a 1" vertical measurement on the paper

CUSTOM SEAMED - TORSO / HEAD



PATIENT'S NAME and/or ID # _____

21 STYLES

CAT. NO.	STYLES	QTY.	PRICE EACH
100525	Sleeveless Vest 1, 10-14, 17		
100524	Vest 1 Long Sleeve 1, 5, 7, 9-17 + arm(s) 1 Short Sleeve		
100526	Vest - 2 Short Sleeves 1, 5, 7, 9-17 + arm(s)		
100527	Vest - 2 Long Sleeves 1, 5, 7, 9-17 + arm(s)		
100530	Sleeveless Body Brief 1, 5, 7, 9-17		
100531	Body Brief with Sleeves 1, 5, 7, 9-17 + arm(s)		
100558	Sleeveless Body Suit 1, 5, 7, 9-17 + leg(s)		
100560	Body Suit with Sleeves 1, 5, 7, 9-17 + arm(s) & leg(s)		
101163	VELCRO® Tabs		
101118	1" Silicone Elastic (Beaded Dot Silicone band)		
100160	2" Silicone Elastic (Beaded Dot Silicone band)		
100150	Beige		
100158	Black		

TOTAL \$0.00

If arm or leg measurements are required go to arm or lower extremity section(s).

22 CIRCUMFERENCES

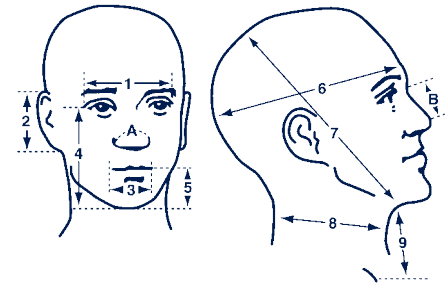
	CIRCUM	HEIGHT
Desired Top of Support		
Waist	1	2
Midpoint Between 1 & 5	3	4
Largest Part of Buttocks	5	6
Proximal Thigh Left (at fold of buttocks)	7	8
Proximal Thigh Right (at fold of buttocks)	9	8
Left Shoulder	10	
Right Shoulder	11	
Neck	12	
Shoulder Width		13
Shoulder to Waist		14
Shoulder to Largest Part of Buttocks		15
Shoulder to Fold of Buttocks		16
Chest	17	
End of Support		
Shoulder to End of Support		
Circumference at End of Support		
Measurement for Bra Cups		
Shoulder to Just Under Breast	A	
Circumference Just Under Breast	B	
Circumference Over Nipple Line	C	

23 TORSO / BODY DESIGN CHOICES

	Front Closure Zipper	Front Closure Velcro	Back Closure Zipper	Back Closure Velcro	Open Axilla LT RT	Self Axilla LT RT	V Neck	Turtle-neck	Scoop Neck
IF YES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24 HEAD MEASUREMENTS

Width of Eyes	1		
Length of Ear	2		
Width of Mouth	3		
Chin to Eyes	4		
Chin to Mouth	5		
Circ. above Eyebrow	6		
Around Head at Chin Angle	7		
Circ. of Neck	8		
Throat to Sternal Notch	9		
Nose Covering Across Tip	A		
Nose Covering Length	B		



25 STYLES / OPTIONS

CAT. NO.	STYLES	QTY.	PRICE EACH
100540	Face Mask		
101158	Open Face Mask		
100550	Chin Strap		
100549	Modified Chin Strap (extends behind ear)		
Options			
101165	Nose Covering		
101166	Lip Covering		
100150	Beige		
100158	Black		

TOTAL \$0.00

JOBST® Custom Seamed

VEST FORM (No Bra Cups)

FAX COMPLETED FORM TO 1-800-863-5935

Email: Sales@acols.com

Date: _____ Purchase Order No.: _____ Fitter.: _____

Patient Name or ID #: _____ Date of Birth: _____ / _____
Month Year

Address _____

Phone: _____ Fax: _____ E-mail*: _____

Account No.: _____

Ship To Address: _____

Bill To Address: _____

Prepaid Invoice Same as Ship To

* By choosing communication via email (above), I acknowledge that Personal Health Information associated with this purchase may be transmitted from BSN in a non-encrypted manner.

DIAGNOSIS: Please Check Appropriate Box(es)

- | | | | |
|--|--|---|---------------------------------|
| <input type="checkbox"/> Edema | <input type="checkbox"/> Thrombotic Syndrome | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Sclerotherapy / Vein Ligation | <input type="checkbox"/> Venous Insufficiency | _____ |
| <input type="checkbox"/> Orthostatic Hypotension | <input type="checkbox"/> Venous Ulcer | <input type="checkbox"/> Arterial Insufficiency | Prescribed pressure: |
| | | | _____ |

1. STYLE			
CAT #		QTY	PRICE
100525	SLEEVELESS VEST		
100524	VEST - 1 LONG SLEEVE, 1 SHORT SLEEVE		
100526	VEST - 2 SHORT SLEEVES		
100527	VEST - 2 LONG SLEEVES		

2. OPTIONS			
CAT #		QTY	PRICE
100150	BEIGE		N/A
100158	BLACK		N/A
100160	2" SILICONE BAND		

3. DESIGN CHOICES		
	YES	NO
FRONT ZIPPER		
HOOK & EYE (2 SETS) BEHIND ZIPPER		
V-NECK		

JOBST® Custom Seamed

VEST FORM (No Bra Cups)

FAX ORDER TO CUSTOMER SERVICE AT: (+1) 800 835 4325

4. BODY MEASUREMENTS

	CIRCUM	LENGTH
LEFT SHOULDER		N/A
RIGHT SHOULDER		N/A
NECK		N/A
CHEST		N/A
SHOULDER WIDTH	N/A	
SHOULDER TO WAIST	N/A	
CIRCUMFERENCE AT WAIST		N/A
SHOULDER TO END OF SUPPORT	N/A	
CIRCUMFERENCE AT END OF SUPPORT		N/A

Please note:

This side of form must be submitted with front side.

5. ARM MEASUREMENTS

WRIST PLEAT	LEFT	TAPE #	RIGHT	WRIST PLEAT
		-6		
		-4 ½		
		-3		
		-1½		
		0		
		+1½		
		+3		
		+4½		
		+6		
		+7½		
		+9 ELBOW		
		+10½		
		+12		
		+13½		
		+15		
		+16½		
AXILLA PLEAT		+18		AXILLA PLEAT
		+19½		



Vests Custom

FAX COMPLETED FORM TO 1-800-863-5935 Email: Sales@acols.com

PAYMENT INFORMATION				Date	
JoViPak Account #		<input type="checkbox"/> Bill to Account		PO #	
<input type="checkbox"/> Charge Credit Card		Card Exp. Date		Patient Name	
Card #				Fax Confirmation #	
Name on Card				Email Confirmation	
BILLING ADDRESS			SHIPPING ADDRESS		
			<input type="checkbox"/> Same as Billing Address		
Business Name				Business Name	
Address				Address	
Attention				Attention	
City		State		City	
Phone		Zip		Phone	
ORDER SPECIFICATIONS					
<input type="checkbox"/> Quote Only		<input type="checkbox"/> Quote & Proceed		<input type="checkbox"/> Dealer Pricing	
				<input type="checkbox"/> MSRP	
RUSH OPTION <input type="checkbox"/> Additional 25% charge for 3 business day production period					
SHIPPING <i>Shipping rates may vary, depending on services requested and/or rates charged by carrier.</i>					
<input type="checkbox"/> FedEx® (2 day shipping) \$10.00 to business addresses; \$13.25 to residential addresses (Additional services may be available; contact JoViPak to discuss.)		<input type="checkbox"/> Check if shipping to a residence		<input type="checkbox"/> USPS Priority Mail Flat Rate® Small or Medium box For PO Boxes only; billed at current USPS rates. (If order does not fit, JoViPak will choose a different shipping method.)	



Vest with with optional Full Padding (shown with vertical & horizontal padding options for illustration)



Vest with recommended JoViJacket

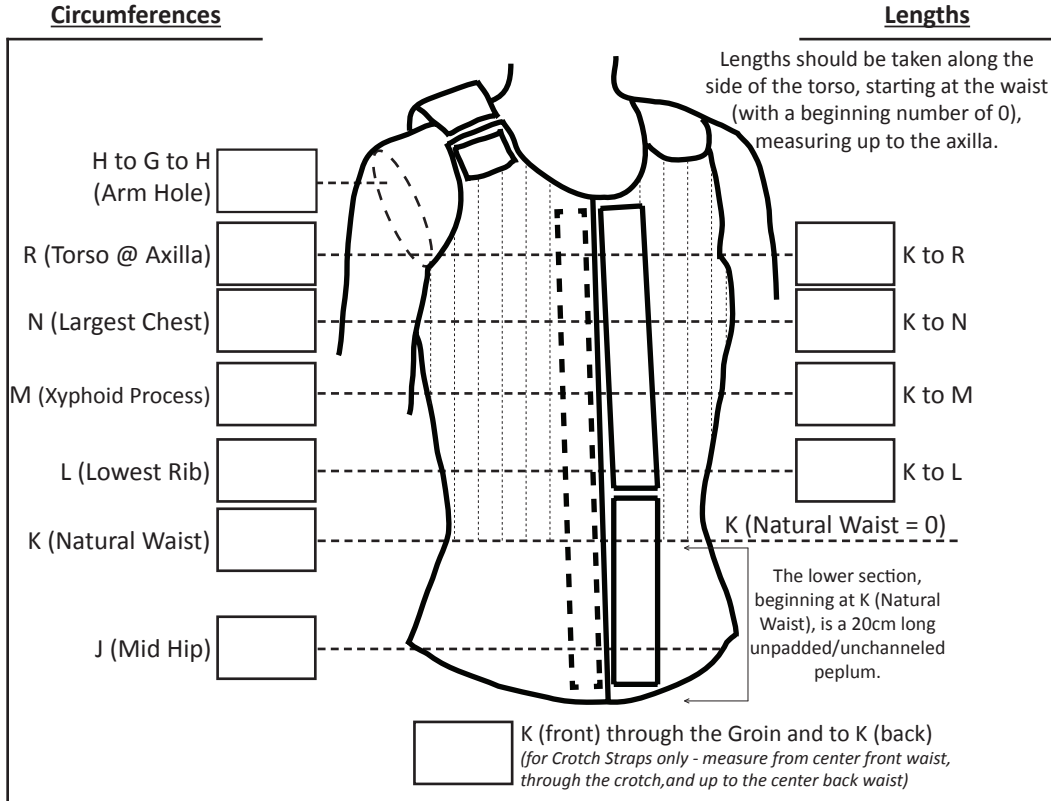
Organic Cotton & Spandex Colors		
<input type="checkbox"/> Black	<input type="checkbox"/> Ivory	<input type="checkbox"/> Royal Blue

JoViJacket - Nylon & Spandex Powernet	
<input type="checkbox"/> Black	<input type="checkbox"/> White (JoViJackets are recommended as they provide the additional compression needed for maximum fit & effectiveness.)

Fitter/Therapist Name: _____ Phone: _____

Patient Name: _____ Previous Patient? Yes No
 Height: _____ Weight: _____ Birthdate: _____ Gender F M
 Mastectomy Left Right Lumpectomy Left Right Reconstruction Left Right

Please record all measurements in centimeters.



No Charge Options

Slimline (more channels and less foam)

Two Blend Foam (Low ILD)

End garment at waist

Additional Charge Options

Padded Insert (equalizes pressure over mastectomy site)

Color: Black Buff

Size: Small (A/B) Medium (C) Large (D) XLarge (DD/E)

Crotch Strap (helps to keep garment in place for patients with larger abdomens (additional measurements required))

Prepaid Reduction

Channeling and Padding

Half Padding (no added charge)

Left Side Right Side

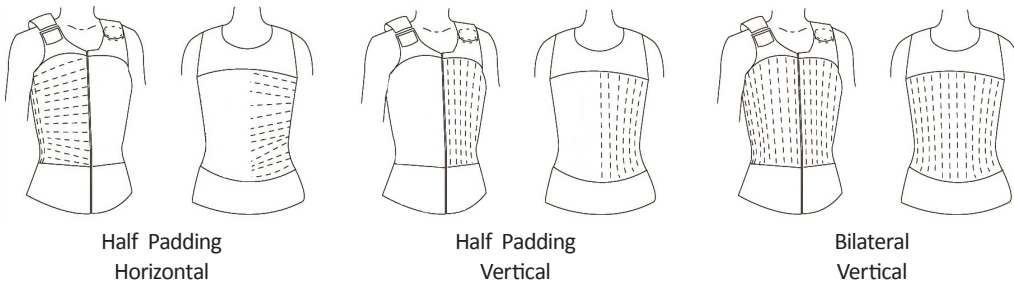
Horizontal Vertical

Full Vertical Padding to natural waist (added charge)

Full Vertical Padding to hemline (added charge)

Pictures are needed if the patient has lobules, is over-sized or has some related issue. Please send pictures (no patient faces) to sales@acols.com

Channeling Options



Comments: _____

Fitter/Therapist Name: _____ Phone: _____



JoViPak

Shoulder-Torso Arm Sleeves Custom

FAX COMPLETED FORM TO 1-800-863-5935 Email: Sales@acols.com

Patient Name: _____

PAYMENT INFORMATION

Account #	<input type="checkbox"/> Bill to Account	Date
<input type="checkbox"/> Charge Credit Card	<input type="text"/> <input type="text"/> Card Exp. Date	PO #
Card #	Fax Confirmation #	
Name on Card	Email Confirmation	

BILLING ADDRESS

Business Name	
Address	
Attention	
City	State
Phone	Zip

SHIPPING ADDRESS

<input type="checkbox"/> Same as Billing Address	
Business Name	
Address	
Attention	
City	State
Phone	Zip

ORDER SPECIFICATIONS

Quote Only Quote & Proceed

SHIPPING Shipping rates may vary, depending on services requested and/or rates charged by carrier

FedEx® (2 day shipping) Check if shipping to a residence \$10.00 to business addresses; \$13.25 to residential addresses (Additional services may be available; contact JoViPak to discuss.)



Standard Two Piece Arm Sleeve with optional Bilateral Arms, Padded Torso, Arm Sling & Dorsum Zipper (This option is an additional charge)



Optional Padded Torso & One Piece Arm Sleeve (This option is an additional charge)



Standard unpadded torso with One Piece Arm Sleeve & recommended JoViJacket (JoViJacket is an additional charge)

Polartec® Power Dry® Colors

<input type="checkbox"/> Black	<input type="checkbox"/> Buff
<input type="checkbox"/> Navy Blue	<input type="checkbox"/> Pink
<input type="checkbox"/> Plum	<input type="checkbox"/> Royal Blue
<input type="checkbox"/> Stainless Steel	<input type="checkbox"/> White (soft pink hue)

Polartec® Silkweight Colors

<input type="checkbox"/> Black	<input type="checkbox"/> Blue Ridge
--------------------------------	-------------------------------------

Garments are produced with Slimline channelling (more channels & less foam than standard channelling) & as a Two Piece garment (separate hand). If a JoviJacket is selected, it will also be Two Piece.

Comments: _____

Fitter/Therapist Name: _____
Phone: _____



JOBST, an Essity brand



Shoulder-Torso Arm Sleeves

Custom

JoViPak

FAX COMPLETED FORM TO 1-800-863-5935 Email: Sales@acols.com

Patient Name: _____ Previous Patient? Yes Gender: F M
 Height: _____ Weight: _____ Birthdate: _____ Left Arm Right Arm
 Mastectomy Left Right Lumpectomy Left Right Reconstruction Left Right

Directions: Follow the dotted lines for measurement guidelines.

BODY

Please record all measurements in centimeters

SS (Neck Line @ Shoulder Seam) SS SS to H (Length: Neck Line to Tip of Acromiom Process)

H to G to H (Arm Hole)

G (Torso @ Axilla)

N (Largest Chest)

M (Xyphoid Process)

L (Lowest Rib) (Recommended Length)

K (Natural Waist)

G to L (Base of Axilla to Lowest Rib) OR G to K (Base of Axilla to Natural Waist) (circle which is being provided)

H to L (Shoulder to Lowest Rib) OR H to K (Shoulder to Natural Waist) (circle which is being provided)

ARM

Lengths (Medial)

C to H

C to G

C to F²

C to F¹

C to F

C to E

C to D¹

C to D

C

C to B

C to A

Garments can be produced with standard channeling or Slimline channeling (more channels & less foam than standard channeling) and as a Two Piece garment (separate hand).
 (No charge option is available for the one piece. JoviJacket would also be a one piece and an additional charge.)
 Measurements are required for accurate fitting garment.

Extra Options

<input type="checkbox"/> Two Blend Foam (Low ILD)	<input type="checkbox"/> Four Blend Foam	<input type="checkbox"/> One piece Arm Sleeve (JoViJacket will also be One Piece)	<input type="checkbox"/> Two piece Arm Sleeve (JoViJacket will also be Two Piece)
---	--	---	---

Additional Charge Options

JoViJacket - Nylon & Spandex Powernet <input type="checkbox"/> Black <input type="checkbox"/> White <small>(JoViJackets are recommended as additional compression is needed for maximum fit & effectiveness.)</small>	Padded Insert (equalizes pressure over mastectomy site) Color: <input type="checkbox"/> Black <input type="checkbox"/> Buff
Arm Sling <input type="checkbox"/> Garment <input type="checkbox"/> JoViJacket	Size: <input type="checkbox"/> Small (A/B) <input type="checkbox"/> Large (D) <input type="checkbox"/> Medium (C) <input type="checkbox"/> XLarge (DD/E)
<input type="checkbox"/> Stitched Finger Glove	<input type="checkbox"/> Dycem®
Pad (sewn in) <input type="checkbox"/> Dorsum <input type="checkbox"/> Palm	<input type="checkbox"/> Easy Slide (for garment without Stitched Finger Glove)
Torso Extension Padding <input type="checkbox"/> Horizontal Channels <input type="checkbox"/> Vertical Channels	<input type="checkbox"/> Prepaid Reduction
Zipper <input type="checkbox"/> Dorsum to mid-forearm <input type="checkbox"/> Wrist to elbow	

Fitter/Therapist Name: _____ Phone: _____



JoViPak

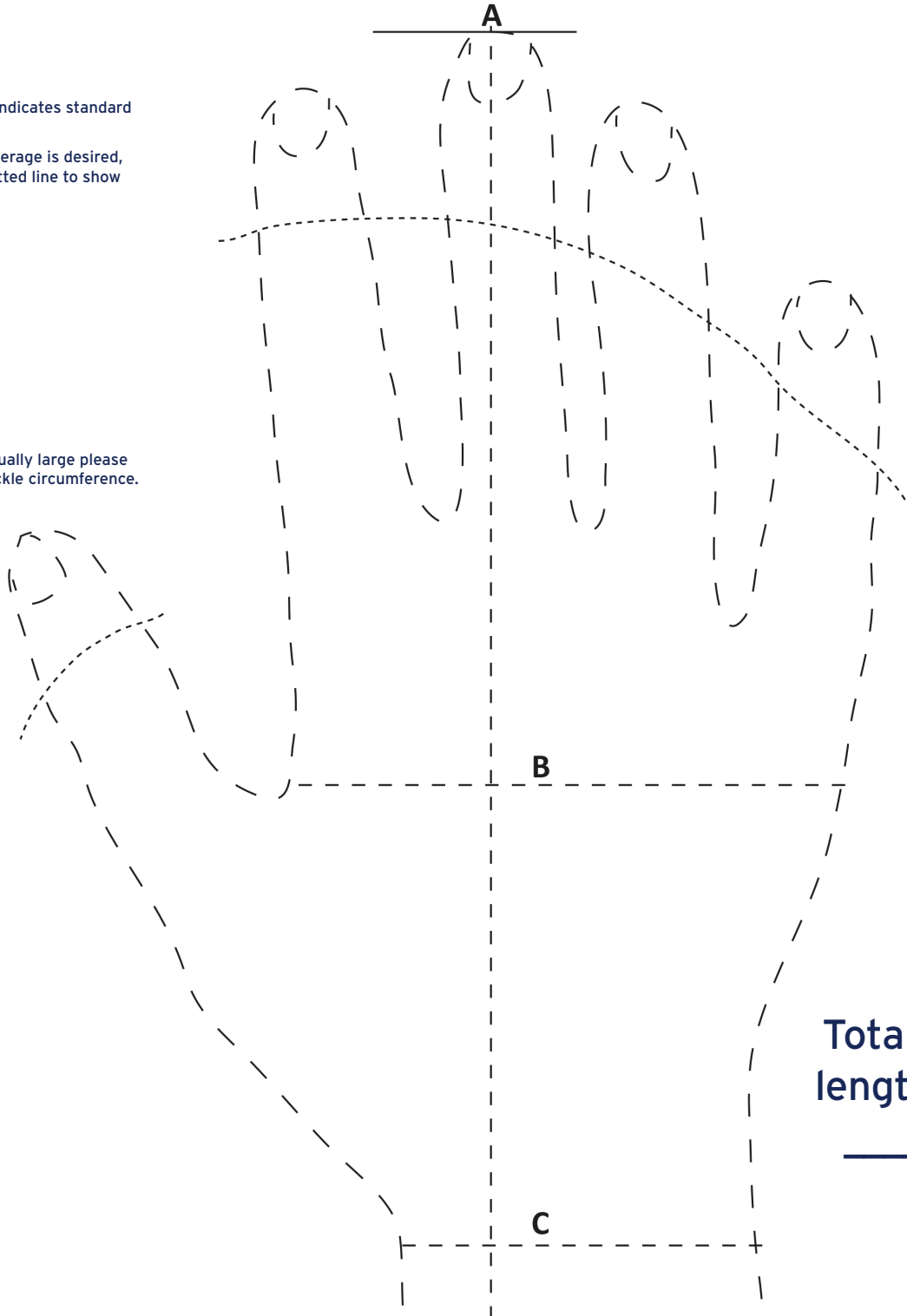
CUSTOM HAND TRACING RIGHT HAND

Place hand flat, directly over this guide, palm down, with wrist flexion crease over the C landmark.
Use a black pen to trace around the hand and each finger.

The dotted line indicates standard hand coverage.

If a different coverage is desired, sketch a new dotted line to show that coverage.

If thumb is unusually large please provide the knuckle circumference.



Total hand length (AC)
_____cm

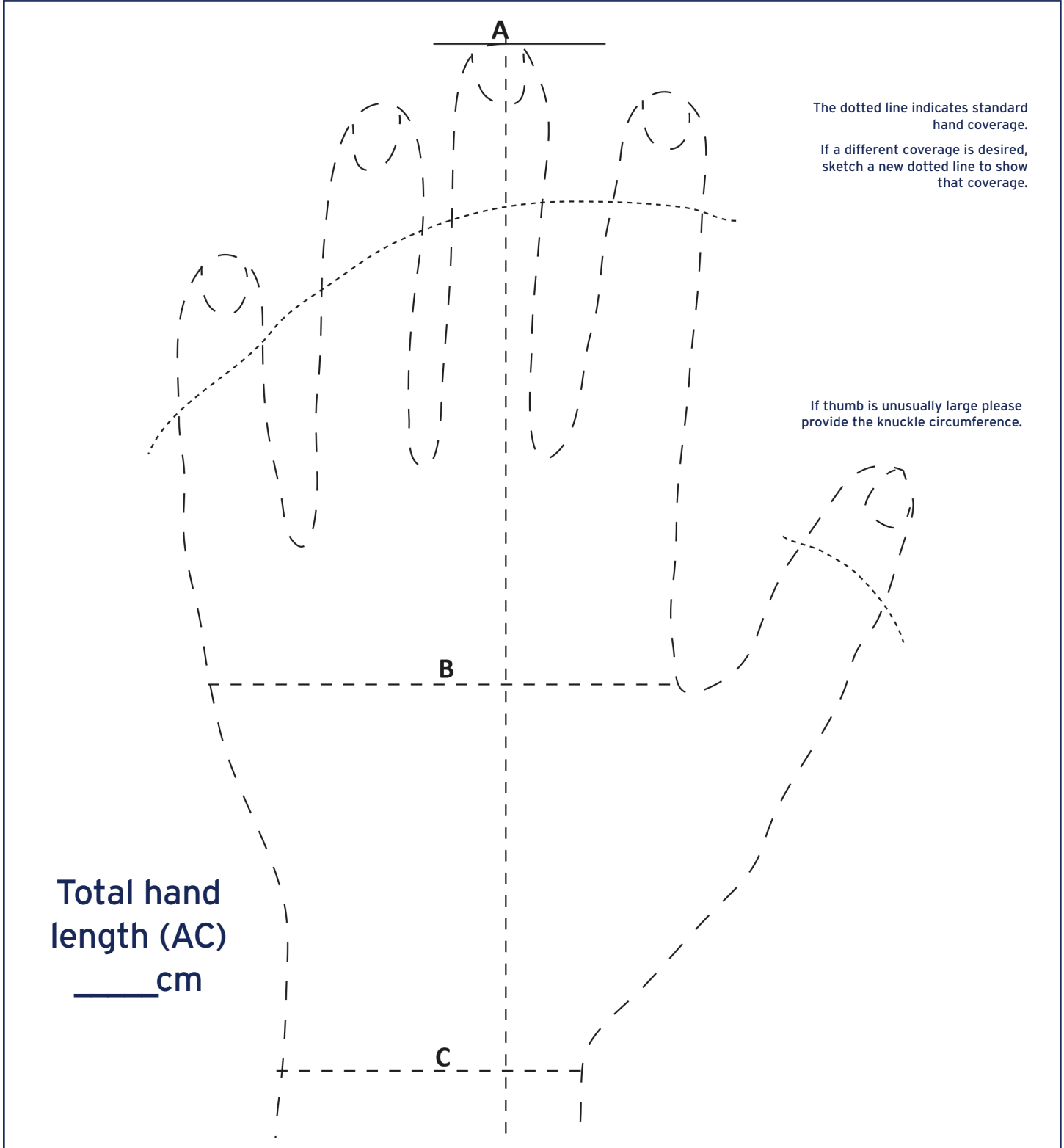
Patient Name or Reference #: _____



JoViPak

CUSTOM HAND TRACING LEFT HAND

Place hand flat, directly over this guide, palm down, with wrist flexion crease over the C landmark.
Use a black pen to trace around the hand and each finger.



Patient Name or Reference #: _____