



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	3 DIAGNOSIS: Please Check Appropriate Box(es) <table style="width: 100%;"><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>	<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 _____	
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2 GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	4 REQUIRED <table style="width: 100%;"><tr><td><input type="checkbox"/> 15-20 mmHg</td><td><input type="checkbox"/> 30-40 mmHg</td></tr><tr><td><input type="checkbox"/> 20-30 mmHg</td><td><input type="checkbox"/> 40-50 mmHg</td></tr><tr><td></td><td><input type="checkbox"/> Other: _____</td></tr></table>	<input type="checkbox"/> 15-20 mmHg	<input type="checkbox"/> 30-40 mmHg	<input type="checkbox"/> 20-30 mmHg	<input type="checkbox"/> 40-50 mmHg		<input type="checkbox"/> Other: _____						
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5 REQUIRED: Date of Birth _____ / _____ / _____ <div style="text-align: right; font-size: small;">Month Year</div> PATIENT NAME _____ Patient File Number _____ <div style="margin-left: 40px; text-align: center; font-size: x-small;">Last Name First</div> <div style="margin-left: 40px;">Address _____ _____ _____ Optional Phone # () _____</div>													
6 DEALER / CLINIC / PRESCRIBER / HOSPITAL _____ Phone # () _____ Facility Account # _____ Order confirmation: Fax No. _____ or E-Mail address _____ Measured By: _____ Fitter # _____													
7 SHIP TO _____ Facility Account # _____ Address _____ Cannot ship to a PO Box _____ _____ _____ Attention _____													
8 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. _____													
9 <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 - FOOT / TORSO

PATIENT'S NAME and/or FILE # _____

12 FOOT MEASUREMENTS

	LEFT		
	RIGHT		

13 ZIPPER OPTIONS

	LOCATION MARK (D)		LENGTH IN INCHES	
	LEFT	RIGHT	LEFT	RIGHT
LATERAL (outside) ASPECT (standard)				
MEDIAL (Inside) ASPECT				
IN BODY ONLY (waist height only)				
Zipper through top support	YES <input type="checkbox"/>	No <input type="checkbox"/>		

15 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					

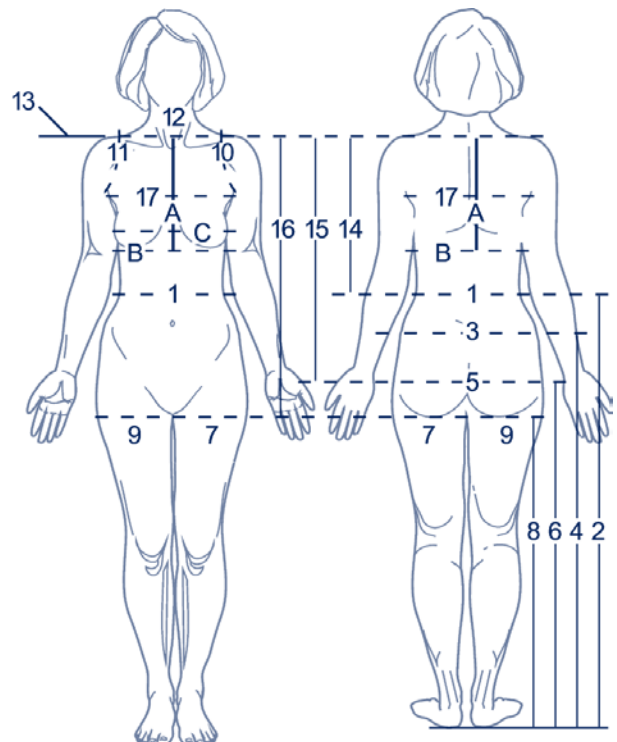
14 STYLES

CAT. NO.	STYLES	QTY.	PRICE EACH
100525	Sleeveless Vest 1, 10-14, 17		
100524	Vest 1 Long Sleeve 1, 10-14, 17 + arm(s) 1 Short Sleeve		
100526	Vest - 2 Short Sleeves 1, 10-14, 17 + arm(s)		
100527	Vest - 2 Long Sleeves 1, 10-14, 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 + <u>leg(s)</u>		
100560	Body Suit with Sleeves 1, 5, 7, 9-17 + arm(s) & <u>leg(s)</u>		
101117	2" Elastic		
100161	2" Custom Sensitive Silicone		
100027	Pocket		
101178	Lining Variation		
101118	1" Silicone Elastic (Beaded Dot Silicone band)		
100160	2" Silicone Elastic (Beaded Dot Silicone band)		
100150	Beige		
100158	Black		

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

16 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"/>



CUSTOM SEAMED - HEAD

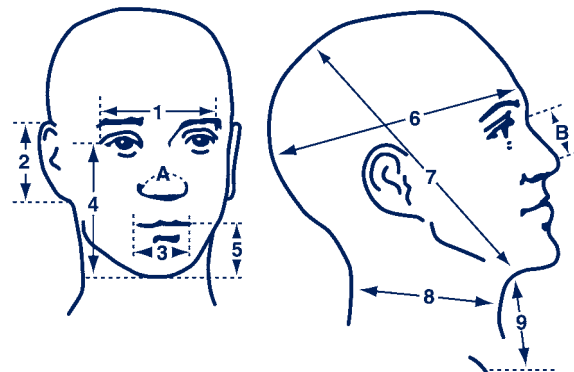
26 HEAD MEASUREMENTS

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		

PATIENT'S NAME and/or FILE # _____

27 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		



ORDER SUMMARY

SUBTOTAL \$	\$0.00
Next Day Ordering Processing Fee	
SERVICE FEE	
\$15 OPTIONAL OVERNIGHT SHIPPING	
(TAXABLE) SUBTOTAL	\$0.00
TOTAL \$	\$0.00

RUSH Service Phone, email or fax orders may receive this priority service if requested. Your order will be completed and shipped from our facility within "1" day of the day of receipt. The service fee is 30% of the total prices entire order, plus the \$15.00 next day air fee. Available in the USA only.

***REQUEST FOR NEXT DAY AIR SHIPPING OPTION ONLY** (USA only) charge of \$15.00

Essity Fee for reading measuring tapes - \$25.00

Please fax your order to: 1-800-835-4325
or email to: seamedorders@essity.com

BSN Medical Inc., an Essity company
1-800-537-1063 option 2

Please enclose remittance or P.O., payable in U.S. funds or their equivalent. Sorry, NO C.O.D.'s

COMMENTS

COMMENTS _____



JOBST[®],
an Essity brand

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