Natural Sole
WELLNESS CENTRE

Natural Sole Wellness Centre Inc.
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Prescription Form

Date: ____________________

Patient's Name: ____________________

Patient's DOB: ____________________

Patient's Phone #: ____________________

Diagnosis/Assessment: ____________________

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Referral For:

MEDICAL COMPRESSION STOCKINGS

- ☐ ABI Testing
- ☐ 15-20mmHg
- ☐ 20-30mmHg
- ☐ 30-40mmHg
- ☐ Length: ____________________
  Pairs: ____________________

DIAGNOSIS

- ☐ Varicose Veins
- ☐ Edema
- ☐ Lymphedema
- ☐ Deep Venous Thrombosis (DVT)
- ☐ Venous Insufficiency
- ☐ Post Surgery
- ☐ Other: ____________________

ORTHOTICS

- ☐ Custom Made Foot Orthotics
  Pairs: ____________________

DIAGNOSIS

- ☐ Plantar Fasciitis
- ☐ Hallux Valgus/Bunions
- ☐ Toe Deformities
  (e.g. Claw/Hammer/Mallet Toes)
- ☐ Heel Spur
- ☐ Lower Limb/ Foot Arthritis
- ☐ Sprain/Tear
- ☐ Scoliosis/Pelvic Tilt
- ☐ Morton's Neuroma
- ☐ Diabetic Foot Ulcer(s)
  Prevention/Management
- ☐ Leg Length Discrepancy
  - R ______ cm/in
  - L ______ cm/in
- ☐ Other: ____________________

REFERRING PROFESSIONAL SIGNATURE: ____________________

PRINT NAME & DESIGNATION: ____________________