

PATIENT

Patient full name

Date of birth

Phone

Shipping address (street, city, state, ZIP)

Email

ORDER

Device: ManaMed Cold Compression Pro system (pneumatic compression pump, cold therapy wrap and gel pack)

Body area: ☐ Knee ☐ Shoulder ☐ Ankle ☐ Hip ☐ Back ☐ Elbow

Side: ☐ Left ☐ Right ☐ Bilateral

Diagnosis / ICD-10 code(s)

Procedure

Surgery / start date

THERAPY PREFERENCES ManaMed Cold Compression Pro: compression 20-100 mmHg; timed sessions up to 120 min.

Compression: ☐ 20 mmHg ☐ 40 mmHg ☐ 60 mmHg ☐ 80 mmHg ☐ 100 mmHg ☐ As tolerated

Session length: ☐ 10 min ☐ 15 min ☐ 20 min ☐ 25 min ☐ 30 min Other (min):

Sessions per day

Time between sessions

Length of therapy (weeks)

Or use through (date)

Other instructions / precautions (or "per manufacturer / as tolerated")

☐ Patient was shown the system in our clinic and wants to purchase it

WRAP FIT (REQUIRED)

Please confirm the wrap fits the treatment area before the patient buys.

Measurement around treatment area (inches)

☐ Wrap fits the patient

☐ Wrap will NOT fit

If the wrap will not fit, the patient should not purchase. All sales are final once purchased; we cannot accept fit returns.

ORDERING PROVIDER

Provider name and credentials

NPI

Practice / facility

Office phone

Office fax

Office contact & email

Provider signature (required)

I certify this equipment is medically appropriate for this patient and that the wrap fit was checked.

Date

NEXT STEPS

1. Fax this completed, signed form to Bonjour Medical at 804-767-2150, ideally the same day.
2. Give the patient our QR code card, or send them to bonjourmedical.com/pages/start-order to buy online.
3. The patient's card is charged only when we receive this Rx; then we ship by ground. No Rx in 7 days = order cancelled.
4. All sales final once purchased: no refunds or exchanges, including for fit. Warranty: pump 1 yr, wraps 6 mo. No insurance billing.