



# Customer Information Order Form

**TO ORDER:**  
<https://order.jobst.com/us>  
Fax: (+1) 800-835-4325

For Questions: 1-800-537-1063 or  
HMS-Elvarex-Orders@essity.com

Customer Information Order Form must accompany Elvarex Lower Ext. Order Form (50333) and Custom Seamless Soft & Bellavar Order form (60873)

**1 DATE** \_\_\_\_\_

Original Order       Quote Only

Reorder with Changes

Order No. or Schema \_\_\_\_\_

**2 GENDER**

Male

Female

**3 DIAGNOSIS** Check Appropriate Box(es)

<input type="checkbox"/> Edema	<input type="checkbox"/> Stasis 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"/> Sclerotherapy/ Vein Ligation
<input type="checkbox"/> Arterial Insufficiency	<input type="checkbox"/> Other

**4 Order Confirmation (FAX # or email address)**

FAX # \_\_\_\_\_

Email Address \_\_\_\_\_

**5 BSN Medical Inc. File #**

\_\_\_\_\_

**Patient Name/ID Code**

\_\_\_\_\_

Last Name First

Address \_\_\_\_\_

City/State/ Zip \_\_\_\_\_

Permanent  Yes  No

Date of Birth (mth/yr) \_\_\_\_\_

Phone \_\_\_\_\_

**6 Physician's Name**

\_\_\_\_\_

Specialty \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Country \_\_\_\_\_

**7 Measured By** \_\_\_\_\_

Custom Fitter # (if applicable) \_\_\_\_\_

Phone \_\_\_\_\_

Facility \_\_\_\_\_

**8 BSN Medical Inc. Account #** \_\_\_\_\_

**Ship To** \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Country \_\_\_\_\_

Attention \_\_\_\_\_

**9 BSN Medical Inc. Account #** \_\_\_\_\_

**Bill To** \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Country \_\_\_\_\_

Attention \_\_\_\_\_

Last 4 digits of credit card on file OR      Exp. \_\_\_\_\_

New card - call to provide credit card #

Name on CC \_\_\_\_\_ Billing Zip \_\_\_\_\_

**10 P.O. #** \_\_\_\_\_



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BSN Medical Inc., an Essity company  
5825 Carnegie Blvd., Charlotte, NC 28209-4633  
Tel. (+1) 704 554 9933 Fax (+1) 800 835 4325  
To order toll-free: Tel. (+1) 800 537 1063