Dear Doctor, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete all sections below, sign and date

|  |  |  |  |
| --- | --- | --- | --- |
| **Client’s Name** |       | **PID** |       |
|  |
| **Address** |       |
|  |  |
| **DOB**  |       | **Telephone** |       |

**Silver Chain Services**

As our home support staff are not nurses, they require an authority/prescription to apply or remove any surgical/medical stockings or garments.

|  |
| --- |
| **Please state reason for stockings/garment** |
|       |

**Placement of Stocking/Garment Style of Garment**

[ ]  Left leg [ ]  Toe to knee stocking

[ ]  Right leg [ ]  Thigh only

[ ]  Both legs [ ]  Full leg stocking

[ ]  Left arm [ ]  Pantyhose/waist

[ ]  Right arm [ ]  Other

[ ]  Both arms

[ ]  Other

**Time of Application** [ ]  **AM** [ ]  **PM**

**Time of Removal** [ ]  **AM** [ ]  **PM**

|  |  |
| --- | --- |
| **Start Date** |       |
|  |
| **End Date (if required)** |       |
|  |  |
| **Review Date** |       |

|  |  |
| --- | --- |
| **Further Information:** |       |
|       |
|       |
|       |
|       |

I hereby authorise Silver Chain home support staff to assist the above client with this regime.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Dr/Consultant |  | Date |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Print Name |       | Contact No |       |