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 |  |