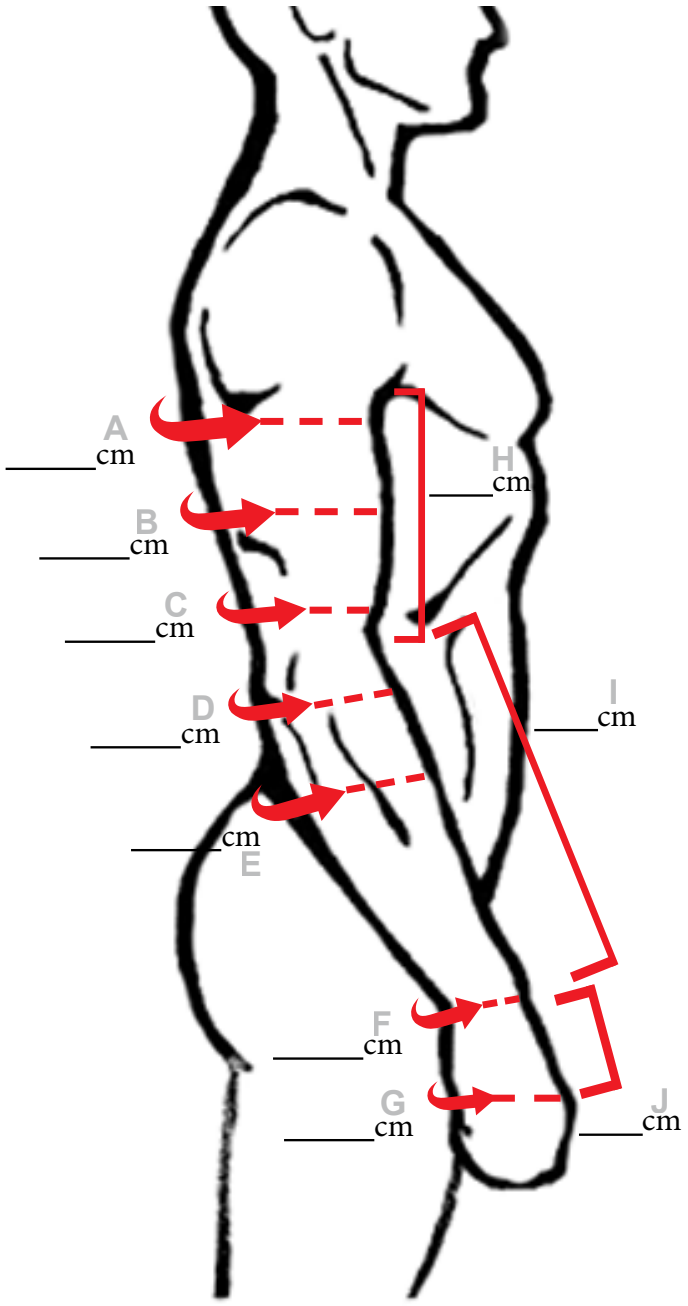
EZ MEDICAL WRAPS: ARM

Measure your patient's arm(s) and fill in the correlating measurements into this chart. Once you have completely filled out the relevant areas, send your measurements to EZ Medical Wraps at nv@ezmedicalwraps.com. If you wrap the fingers give measurements after the fingers are wrapped.

Patent Pending

Patient Name _____ **Date** _____

Right Arm

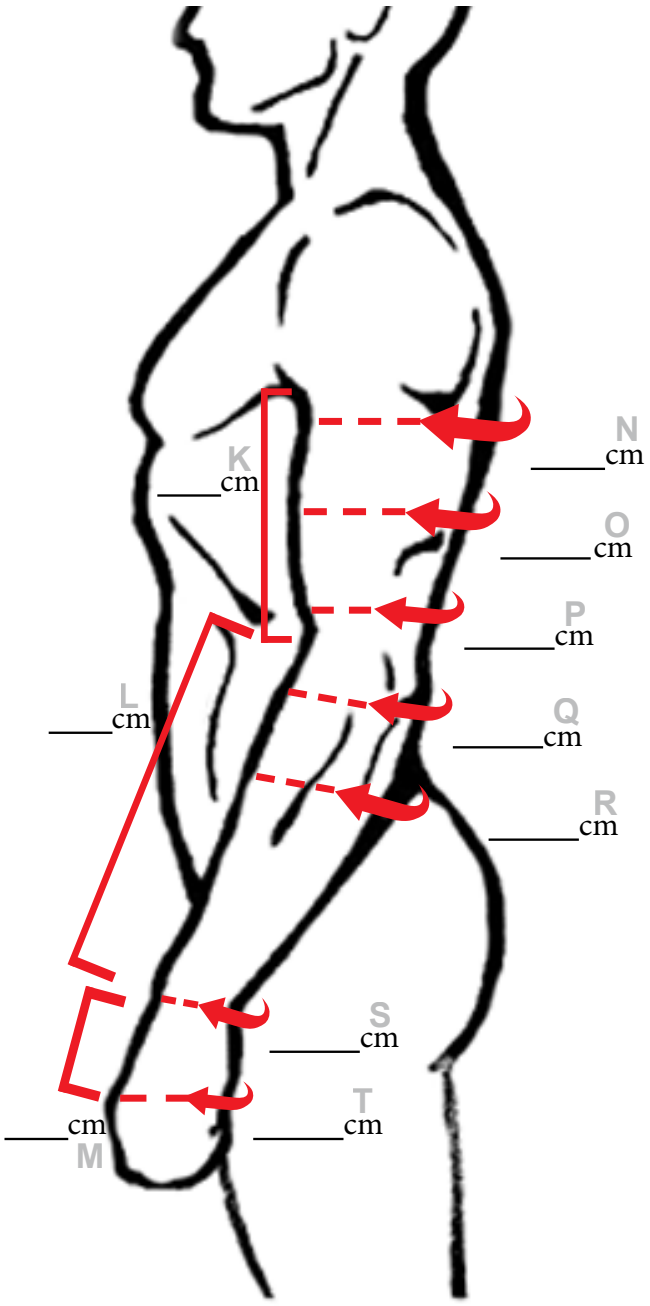


FOR FOAM COMPRESSION WRAP:

Hand Extension: ☐ Yes ☐ No

☐ One Piece ☐ Two Piece

Left Arm



FOR FOAM COMPRESSION WRAP:

Hand Extension: ☐ Yes ☐ No

☐ One Piece ☐ Two Piece