Date: [Insert Date]

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Date of Birth]
Diagnosis: Deep Vein Thrombosis (DVT) / Post-Thrombotic Syndrome

To Whom It May Concern,

This letter serves as a formal prescription for medical-grade compression garments for the above-named patient. The patient has a confirmed diagnosis of Deep Vein Thrombosis and requires these garments to manage symptoms, prevent complications, and reduce the risk of Post-Thrombotic Syndrome.

Prescription Details:

- **Garment Type:** [e.g., Knee-high, Thigh-high, or Pantyhose]
- **Compression Level:** [e.g., 20-30 mmHg or 30-40 mmHg]
- **Quantity:** [e.g., 2 pairs]
- **Affected Limb(s):** [e.g., Left Leg, Right Leg, or Bilateral]
- **Duration of Use:** [e.g., Daily for 6 months / Indefinite]

These garments are medically necessary for the treatment of this condition. Please provide the patient with the appropriate sizing based on professional measurements.

Sincerely,

[Physician Signature]

Physician Name: [Insert Name]
NPI Number: [Insert Number]
Clinic Name: [Insert Clinic Name]
Phone Number: [Insert Phone Number]