



# ProActive

## ATHLETIC THERAPY

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Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

R<sub>x</sub>

MEDICAL COMPRESSION SOCKS

20-30mmHg

Brand: ACHI+

Diagnosis: \_\_\_\_\_

# of pairs per year: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_