

LYMPHA PRESS ARM SLEEVE MEASURING FORM

Date: _____ Patient Name: _____

	CIRCUMFERENCE	
	LEFT	RIGHT
AXILLA	<input type="text"/>	<input type="text"/>
ELBOW	<input type="text"/>	<input type="text"/>
MID FOREARM	<input type="text"/>	<input type="text"/>
WRIST	<input type="text"/>	<input type="text"/>

MEASURE IN
 CM INCHES

NOTES: _____

