

OUTPATIENT CANCER REHABILITATION ORDER FORM



Patient name: _____ Date: _____

Phone: _____ E-mail: _____

<input checked="" type="checkbox"/> EVALUATE AND TREAT		
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech / Swallowing Therapy

Medical / oncologic diagnosis:

Precautions / special instructions:

Check your patient's impairment(s) under the requested therapy discipline(s):

Physical Therapy

- Pain
- Cancer-related fatigue
- Weakness / deconditioning
- Gait / balance problems
- Neuropathy
- Range of motion problems
- Lymphedema
- Radiation fibrosis syndrome
- Shoulder problems
- Axillary web syndrome
- Arthralgias / myalgias
- Pulmonary insufficiency
- Bowel / bladder problems
- Sexual dysfunction
- Trismus

Occupational Therapy

- ADL impairments
- Pain
- Cancer-related fatigue
- Weakness / deconditioning
- Neuropathy
- Range of motion problems
- Lymphedema
- Shoulder problems
- Radiation fibrosis syndrome
- Axillary web syndrome
- Cognitive impairments
- Arthralgias / myalgias
- Hand therapy

Speech / Swallowing Therapy

- Dysphagia / dysarthria
- Trismus
- Head and neck lymphedema
- Range of motion problems
- Cognitive impairments

Name (print): _____ Signature: _____

Date: _____ Time: _____ NPI# _____

**Cancer rehabilitation services are provided at specialized therapy centers.
For program and location information visit: revitalcancerrehab.com**

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