OUTPATIENT CANCER REHABILITATION ORDER FORM

ReVital Cancer Rehabilitation

Patient name: _____ **Date:** _____

Phone: _____ **E-mail:** _____

☑ EVALUATE AND TREAT		
☐ Physical Therapy	☐ Occupational Therapy	☐ 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 clinics.
For program and location information visit: revitalcancerrehab.com

Phone: 817-333-0181 ext. 1181 **Fax:** 817-333-0184 **E-mail:** revital@selectmedical.com revitalcancerrehab.com

Clear Form