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
☐ 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

Phone: 844.473.8485 | Revital@selectmedical.com