OUTPATIENT CANCER REHABILITATION ORDER FORM

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

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