



**PHYSICAL THERAPY
ONCOLOGY REHAB PROGRAM**

- Rockford
- Dixon

Certified Specialists in Physical Therapy

Name: _____

Phone: _____ D.O.B. _____

Diagnosis: _____ Dx Code: _____

Surgical History: _____

Please send op-reports

Cancer Treatment

- Radiation Therapy
- Chemotherapy
Drug Combination _____

Contraindication for Lymphedema Management:

- CHF
- Infection/Cellulitis
- Anticoagulant Therapy
- Renal Insufficiency

Evaluation & Treatment

- Therapeutic Exercise
- Mobilization/Manual Therapy
- Functional Restoration
- Cardiovascular Conditioning
- Lymphedema Management
(Bandages/Supplies)
- Aquacizer
- Desensitization/Re-education
- ROM
- Home Program

Modalities of Choice

- Hot/Cold Pack

Frequency: _____ per week, for _____ weeks

Instructions/Precautions: _____

THE PATIENT WILL TYPICALLY BE EVALUATED WITHIN 24-48 HOURS.

- Please check here if patient needs to be seen sooner.

Dr. _____ Date: _____

• This prescription is a statement of medical necessity for the above named patient •

Orthopedic Rehab Specialists
2662 McFarland Rd. • ROCKFORD
815.227.1700 • Fax: 815.227.1744

Orthopedic Rehab Specialists
201 Lincoln Statue Dr. • DIXON
815.284.1700 • Fax: 815.284.1704