H.O.P.E. Life
Lymphedema & Rehab Center

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Hilton Head, SC 29928
Phone: 843-715-4146
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Physician Referral Form

Patient Name: _____ D.O.B.: _____
Patient Contact Number: _____
Therapy Diagnosis: _____ ICD-10: _____
Medical Diagnosis (if applicable): _____ ICD-10: _____
Precautions: _____ Next MD apt.: _____
Patient Goal: _____

Treatment Orders

Specific Instructions: _____

General Physical Therapy	Oncology	Lymphedema
☐ **Evaluate and Treat**	☐ **Evaluate and Treat** Please send most recent labs and/or Progress Note	☐ **Evaluate and Treat**
☐ Range of Motion Restoration	☐ Debilitation Risk Reduction Program ☐ -Pre-surgical Program ☐ -Post-Surgical Program	**Complete Decongestive Therapy**
☐ Progressive Strenthening ☐ Modalities: (E-stim, U.S., Heat, Ice, Iontophoresis, Other:_____) ☐ -Spasm Reduction ☐ -Pain Modulation ☐ -Muscle Re-eduction		☐ Right Upper Limb ☐ Left Upper Limb ☐ Bilateral Upper Limbs
☐ Postural/Movement Mechanics Restoration ☐ Core Stabilization ☐ Gait/Balance ☐ Functional Independence Re-Training: ☐ -Self Level ☐ -Household Level ☐ -Community Level	☐ Deconditioning Syndrome Progressive Program ☐ -Chemotherapy Induced ☐ -Radiation Induced ☐ Palliation Program ☐ -Functional Quality of Life preservation ☐ -Non-pharmacological Pain modulation	☐ Right Lower Limb ☐ Left Lower Limb ☐ Bilateral Lower Limb ☐ Other

Treatment Frequency/Duration: _____ Times/week for: ____ Weeks:

I hereby certify these services as medically necessary for the patient's plan of care.

Physician Name: _____ Date: _____

Physician Signature: _____