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LYMPHEDEMA AND
REHAB CONSULTANTS, PLLC

(p) 804-505-4849
(f) 844-715-9467

REFERRAL FORM

Section 1 (optional if attaching a face sheet)

Patient Name: ______________________________

D.O.B: ____/____/____ DATE: ____/____/____ SSN#________-________-________

Patient Phone #: ________________________ Family/ Caregiver Phone #: ________________________

MEDICARE/PRIMARY
INSURANCE PLAN: ______________________

SECONDARY
INSURANCE PLAN: ______________________

POLICY #: ______________________

POLICY #: ______________________

Section 2 (**REQUIRED**)

DISCIPLINE: (PLEASE, **CHECK ALL** THAT APPLY.) PT/OT________ PT____________ OT____________

EVALUATE AND TREAT: (PLEASE, **CHECK ALL** THAT APPLY AND SPECIFY BODY PART TO BE ADDRESSED)

- ___Oncology-related Lymphedema: ____________________
- ___Lymphedema of Unknown Etiology: ________________
- ___Lipedema: ____
- ___Wound Care: (please, specify the following:
  - Location: ______________________________
  - Origin/ Etiology: ________________________
- ___Post-Surgical Edema: ____________________________
- ___Traumatic Edema: ________________________________
- ___Pain: (location/ severity/ etiology): __________________
  ____
- ___Custom Compression (with or without silicone):
  ____

- ___ADL Re-training
- ___Strengthening/ Endurance Training
- ___Mobility/ Gait Training
- ___Oncology-related Deconditioning
- ___Pneumatic Compression Pump Ordering
- ___Manual Therapy (scar massage, MLD, etc)
- ___Falls/ Balance Assessment & Training
- ___Home Safety Assessment
- ___Other: ______________________
  ____
  ____

Comments/ Concerns: ________________________________

PRESCRIBING PHYSICIAN/NP/PA

Prescriber Name: ______________________________

NPI#______________________________ **DATE:** ____/____/____

PRESCRIBER SIGNATURE: ______________________________

OFFICE ADDRESS: ______________________________
____

OFFICE (p): ________________________
OFFICE (f): ________________________

Please, attach:

FACE SHEET___ **LAST MEDICAL NOTE WITH A LIST OF MEDICATIONS**___ **SCRIPT/ ORDER:** ___

*Name of Home Health or Rehab Facility *(if applicable)* ______________________________
Person of Contact: ______________________________