



**CANADIAN
LYMPHEDEMA
REHABILITATION**
SERVICES INC.

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E-mail: lymphrehab@hotmail.com

Prescription to Assess and Treat:

Please complete and email or fax this form to our office. We will contact your patient directly to schedule an assessment, then confirm the date with your office.

Patient's Name: _____ Date: _____

Patients Phone Number(s): _____

Diagnosis and Relevant Medical History (Please forward medical reports as indicated):

Occupational Therapy to assess and treat:

Lymphedema:

Upper extremity: Right Left

Lower extremity: Right Left

Other (Please specify):

Comments:

Physician Signature: _____

Print Name: _____

Phone #: _____ Fax #: _____

(Note: A separate prescription will be required for appropriate compression garments if indicated.
The therapist will provide specific recommendations after assessing and treating your patient.)