



**CALGARY
LYMPHEDEMA
REHABILITATION**
AND CONSULTING SERVICES INC.

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Prescription to Assess and Treat:

Patient's Name: _____ Date: _____

Phone Number: _____ ACB# (if appropriate): _____

Diagnosis/Pertinent Medical history (Please enclose recent progress note if available):

Physical /Occupational/Massage therapy to assess and treat:

Lymphedema: Upper extremity: Right/Left
(please circle)

Lower extremity: Right/Left

Bilateral: Upper extremity/ Lower extremity

Other region(s): (Please specify)

Therapist to contact patient directly to schedule an appointment? Yes/No

Therapist to contact referring physician prior to starting treatment? Yes/No

Comments:

Physician Signature: _____

Print Name: _____

Phone #: _____ Fax #: _____