TORRANCE MEMORIAL
A CEDARS-SINAI AFFILIATE

Hunt Cancer Institute

Torrance Memorial Medical Center
Oncology Rehabilitation Services Referral

Name:_____ **Phone:**_____

Diagnosis:

Date of onset:

Precautions/Contraindications:

☐ OT/PT for lymphedema evaluation and management

☐ Occupational therapy evaluate and treat for any of the following:

- Impaired ability to do self-care, home or community skills (ADLs)
- Impaired activity tolerance
- Cognitive changes affecting ADLs
- Impaired upper extremity function (gross/fine motor, sensation)

☐ Physical therapy evaluate and treat for any of the following:

- Generalized weakness/deconditioned
- Impaired range of motion/joint function
- Impaired mobility
- Cancer related fatigue
- Impaired balance

☐ Speech therapy evaluate and treat for any of the following:

- Swallowing difficulties
- Impaired speech/voice
- Impaired oral motor skills

☐ Frequency and duration:_____x a week for _____weeks

Physician's name:_____ **Fax:**_____

Physician's signature:_____ **Date:**_____ **Time:**_____