

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: _____



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