LYMPHEDEMA ORDERS

NAME: ____________________ DATE: ____________

DOB: ____________ PATIENT'S PHONE: ____________________

DIAGNOSIS: ____________________ ICD-9: ____________

Lymphedema evaluation and treatment of ____________________ extremity.
left/right/bilateral upper/lower

Treatment to include manual lymphatic drainage, multi-layer compression bandaging, therapeutic exercises, and a final compression garment.

Patient is to be seen 3-5 days per week for entire length of treatment.

PHYSICIAN SIGNATURE: ______________________________

PHYSICIAN NAME: ______________________________

PHYSICIAN PHONE: ____________ FAX: ____________

NOTE TO PATIENT: Please bring this order with you for your appointment. You will need to arrive about 15 minutes before your appointment time to complete initial paperwork.

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