CANCER CENTER OUTPATIENT THERAPY AND PHYSICIAN SERVICES PRESCRIPTION

Clinic Use Only
Appt. Date: _____ / _____ / _____
Appt. Time: ________ am/pm

Patient Name:	**DOB:**	**Goals:**
Phone: H	**W**	**Cell/Mobile:**
Date of Onset/Exacerbation:		**Previous Therapy Results:**
Diagnosis:		**ICD-9:**
Post Op: ☐ Yes ☐ No	**Surgery Date:**	**Designated Therapist:**
Special Precautions/Weight Bearing Status:		**Transplant Patient:** ☐ Yes ☐ No

Fax Completed Referral to: 214-818-8887 **Scheduling Phone: 214-820-8577**

PHYSICAL MEDICINE & REHABILITATION PHYSICIAN SERVICES▲

☐ Consult: Physical Medicine Physician
☐ Consult: Injections/type ________________
☐ Acupuncture
☐ Consult: Physician for EMG/NCS
☐ Consult: Spasticity Management - Botox/Baclofen Pump
☐ Other (specify) ________________

Oncology Physical Therapy

☐ Evaluate & Treat
- ☐ Patient/Family Education ________________
- ☐ Deconditioning
- ☐ Stiffness of joint or contracture
- ☐ Muscle Weakness
- ☐ Exercise
- ☐ Manual Therapy
- ☐ Difficulty Walking
- ☐ Balance/Safety
- ☐ Cachexia
- ☐ Aquatics
- ☐ Healthy-Steps©™
- ☐ Other ________________

Oncology Occupational Therapy

☐ Evaluate & Treat
- ☐ Patient & Family Education
- ☐ ADL Training
- ☐ Decreased Functional Mobility/Safety
- ☐ Energy Conservation/Work Simplification
- ☐ Pain Management (Non Pharmacological Options)
- ☐ Muscular weakness & wasting/ Contractures of the joint
- ☐ Malaise & Fatigue
- ☐ Cachexia
- ☐ Exercise
- ☐ Healthy-Steps©™
- ☐ End of Life/Quality of Life Interventions
- ☐ Complementary Techniques ________________
- ☐ Other ________________

Oncology Women's Health PT

Pelvic Floor, Pain, Incontinence
Refer to the Tom Landry Center BIR Outpatient Therapy
Women's Health Program
214-820-2608

Lymphedema-PT/OT

☐ PT/OT Evaluate & Treat
- ☐ Manual Lymphatic Drainage
- ☐ Patient/Family Education ________________
- ☐ Compression Bandaging
- ☐ Fitting for Compression garments
- ☐ Skin Care
- ☐ Exercise
- ☐ Aquatics
- ☐ Healthy-Steps©™
- ☐ Other ________________

Oncology Speech Therapy

☐ Evaluate & Treat
- ☐ Dysphagia Evaluation/Therapy
- ☐ Modified barium Swallow
- ☐ Fiberoptic Endoscopic Evaluation of Swallow
- ☐ Stroboscopy Evaluation
- ☐ Tracheoesophageal Prosthesis Placement/Management
- ☐ Voice Evaluation
- ☐ Other ________________

*****To comply with Federal regulations the patient name, diagnosis, procedure, physician signature, date and signature time are required***

I hereby certify these services as medically necessary for the patient's plan of care.

*****Physician/Provider Signature***	***Date***	***Time***
Physician/Provider Name Printed	Office #	NPI #

▲Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System or its affiliated medical centers.
■ = HealthTexas Provider Network Practice

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

54113 (07/13)

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