"Specializing In One-On-One Care for Lymphedema Therapy and Cancer Rehabilitation"

EMINENCE PHYSICAL THERAPY REFERRAL FORM

Patient Name:______________________________DOB:_____/_____/_____Tel #: _________________

Patient Diagnosis:____ICD-10 Code:______________

Patient Precautions: ____

Please Check Needed Treatment Below:

_____ Physical Therapy Evaluation and Treatment for Lymphedema

_____ Physical Therapy Evaluation and Treatment for Breast Cancer Rehabilitation

_____ Physical Therapy Evaluation and Treatment for General Cancer Rehabilitation

_____ Physical Therapy General Evaluation and Treatment: Perform Dry Needling As Needed

Frequency and Duration of Treatment:___________times weekly for____________weeks or per therapist's discretion.

I certify that these services are medically necessary for the patient's plan of care.

Physician's Signature:_______________________________________Date: _______________________

Physician's Printed Name:__________________________________NPI#:_________________________

Physician's Practice Name and Address:

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Provider's Phone Number:_______________________ Provider's Fax Number:_______________________

Please send this form completed in its entirety to: info@eminencept.com or fax to 770-818-5878.

Dr. Crystal Champion, PT, DPT, CLT-ALM, Cert. DN
Doctor of Physical Therapy & Certified Lymphedema Therapist

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