



**CALGARY
LYMPHEDEMA
REHABILITATION**
AND CONSULTING SERVICES INC.

Holy Cross Medical Center
#112 A – 2310 – 2nd St. SW, Calgary, Alberta. T2S 3C4
Ph: (403) 209-6537 Fax: (403) 209-6587
E-mail: info@calgarylymphedema.com

Prescription to Assess and Treat:

Patient's Name: _____ **Date:** _____

Phone Number: _____ **ACB# (if appropriate):** _____

Diagnosis/Pertinent Medical history (Please enclose recent progress note if available):

Physical /Occupational/Massage therapy to assess and treat:

Lymphedema: **Upper extremity: Right/Left**
(please circle)

Lower extremity: Right/Left

Bilateral: Upper extremity/ Lower extremity

Other region(s): (Please specify)

Therapist to contact patient directly to schedule an appointment? Yes/No

Therapist to contact referring physician prior to starting treatment? Yes/No

Comments:

Physician Signature: _____

Print Name: _____

Phone #: _____ **Fax #:** _____