***Your Logo Here!***

* Contact Information: ***Therapist Name & Phone Number***

**LYMPHEDEMA EVALUATION:**

**Referring Clinician:**

Last:       First:       DOB:       Age:       Gender:

Assessment Date:

Medical Diagnosis:       Treatment Diagnosis:

Type of Therapy:

Start Time:       End Time:       Total Time:

Charges:  Time:        Time:

Reason for referral: Intractable lymphedema of the , unrelieved by elevation.

**Lymphedema History:**

Chief Complaint:

▒ = lymphedema xxxx= fibrotic tissue ooo= pitting edema ///= pain



Onset:       Triggering Event:

Past History:

[ ] Surgery:

[ ] Radiation Therapy:

[ ] Chemotherapy:

[ ] Lymph node removal:

[ ] History of Cellulitis/Infection:

[ ] Family history of lymphedema:

[ ] Previous treatment for lymphedema:

[ ] Current compression garment use:

Medical History:

Medications:

Allergies:

Pain:  Location:       Description:

Objective observations:( ROM, MMT, Skin Integrity, etc.)

Measurements: see limb volume calculations-attached

Prior Level of Function:

Living Situation:

Self Care:

Grooming:  Bathing: Dressing:  Other:

Gait:

Functional Limitations:

Precautions:

Rehab Potential: This patient demonstrates the ability to follow the plan of care and progress towards goals. Rehab potential is

Prognosis: . During this plan of care, this patient will demonstrate optimal reduction in girth, joint mobility, muscle performance, ROM and highest level of function in home, community, recreation and work activities.

Rationale for Skilled Therapy/Medical Necessity:

**Goals:**

Patient goals:

STG:

[ ] Patient will demonstrate knowledge and understanding for lymphedema precautions, skin care and self management to decrease progression of lymphedema and risk of infection.

[ ] Patient will present with decreased limb volume in the involved extremity from       to       for improved functional mobility.

[ ] Patient will demonstrate compliance with compression therapy for independent management of lymphedema.

[ ] Other:

LTG:

[ ] Patient will be independent with self management of lymphedema including understanding garment wear schedule, self compression bandaging, HEP and self care.

[ ] Patient will be fitted for appropriate compression garments for long term management of lymphedema.

[ ]  Patient will present with decreased limb volume in the involved extremity from       to       for improved functional mobility.

[ ] Other:

**Assessment:** , , Affecting the .

Patient is a pleasant       year old  who presents to Klose Lymphedema Care with      . Patient will benefit from a **Complete Decongestive Therapy** protocol using manual lymphatic drainage techniques, skilled multilayer compression bandaging using short stretch bandages and foam padding, instruction in a home program of self massage and exercise, compression garment fitting and instruction in independent management strategies for lymphedema.

**Plan of Care: (frequency/duration)**

[ ] 97140-Manual Lymph Drainage and Combined Decongestive Therapy

[ ] 97110- Skilled Multilayer Short Stretch Compression Bandaging/ Therapeutic Exercise

[ ] Skin Care Education [ ] HEP including Self MLD Education and/or Self Bandaging

[ ] Education for Lymphedema Risks/Precautions [ ]  Caregiver Education [ ] other:

SOC:       Certification From:       Through:

Dr.      ,

Thank you for this referral. If you have questions about this patient please contact me at 303-245-0333. The patient and I have planned the above goals and s/he will be provided with a treatment protocol and home program to help achieve them.

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Therapist Name & Title***

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name:

***I CERTIFY THE ABOVE PRESCRIBED SERVICE ARE REQUIRED FOR THIS PATIENT AND ARE MEDICALLY NECESSARY. THE ABOVE PLAN OF CARE HAS BEEN DEVELOPED IN CONJUNCTION WITH THE LYMPHEDEMA/PHYSICAL THERAPIST.***

\*\*\*PLEASE SEE BELOW\*\*\*

Dr.      :

Do you deem this patient’s cardiac status adequate to manage the increased fluid load brought to the heart/venous system through complete decongestive therapy with lymphatic mobilization techniques? (125mL/hour through the thoracic duct)

YES\_\_\_\_\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name: