CONE HEALTH

CANCER REHAB REFERRAL

Patient Name:_________________________ **Date of Birth:**_________________________

Medical Diagnosis:____

Patient phone: Home______________ **Cell**__________________ **Other**________________

☐ **Interpreter needed. Language:** _________________________________

☐ **Physical therapy eval and treat as needed**

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☐ **ABC (After Breast Cancer) class on exercise and lymphedema** *(one time free class for post-surgical breast cancer patients)*

☐ **Speech language pathology eval and treat as needed** *(Neurorehabilitation site only)*

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☐ **Audiological evaluation: Diagnostic testing** *(both baseline & monitoring)* **as indicated**

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☐ **Occupational therapy eval and treat as needed** *(Neurorehabilitation site only)*

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Cancer-related conditions you would like addressed:

- ☐ **Axillary cording/Brachial plexopathy**
- ☐ **Balance impairment**
- ☐ **Cardiopulmonary rehab**
- ☐ **Fatigue/Deconditioning**
- ☐ **Lymphedema**
- ☐ **Osteoporosis/Osteopenia**
- ☐ **Pain control**
- ☐ **Pelvic floor dysfunction/Incontinence**
- ☐ **Peripheral neuropathy**
- ☐ **Range of motion deficits**
- ☐ **Strength deficits**
- ☐ **Swallowing difficulties** *(Neurorehab site only)*
- ☐ **DPOAEs (Oto-toxicity)**
- ☐ **Tympanometry/Impedance Audiometry**

MD Signature ___________________________ **Date** ___________________________

Referral from: ___________________________ **Office Telephone:** ___________________________
(*Office Name*)

Office Contact: ___________________________ **Fax:** ___________________________

Primary MD: ___________________________ **Insurance:** ___________________________
(if different from referring MD)

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3800 Robert Porcher Way
Suite 400
Greensboro, NC 27410
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Fax 336-282-6354

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912 Third Street
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Brassfield

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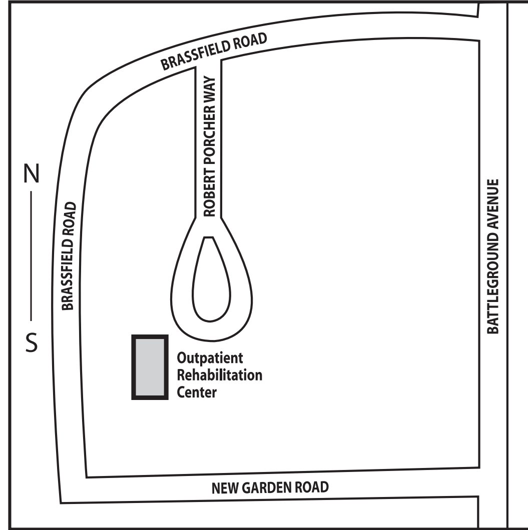

Cancer Rehab Center

1904 North Church Street
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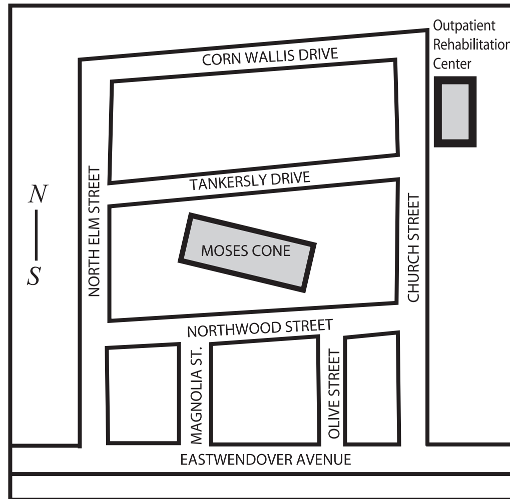

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