

	Name _____ Medical Record No. _____ Date of Birth _____
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ONCOLOGY REHABILITATION MEDICINE REFERRAL FORM

REFERRING PHYSICIAN: _____

CANCER DIAGNOSIS: _____

REASON FOR REFERRAL:

- Pain (For patients with no evidence of disease)
 - A. Consider a Palliative Care Consult for patients with Pain and currently have an active cancer diagnosis and/or psychosocial needs.
 - B. Consider an Anesthesia Pain Consult if patient has active disease and is a surgical referral or needs a specific intervention, i.e. celiac plexus block, epidural placement.
- Joint Injection
- Fatigue
- Weakness
- Muscle Spasms
- Neuropathy
- Myopathy
- Deconditioning
- Contractures
- Trismus/Swallowing and Chewing Problems
- Radiation Fibrosis
- Dystonia
- Spasticity
- Lymphedema
- Amputation
- Gait Disorder, Poor Balance/Recent Falls
- Other _____

ROUTINE _____

URGENT _____

NOTES: _____

SIGNATURE: _____ DATE: _____

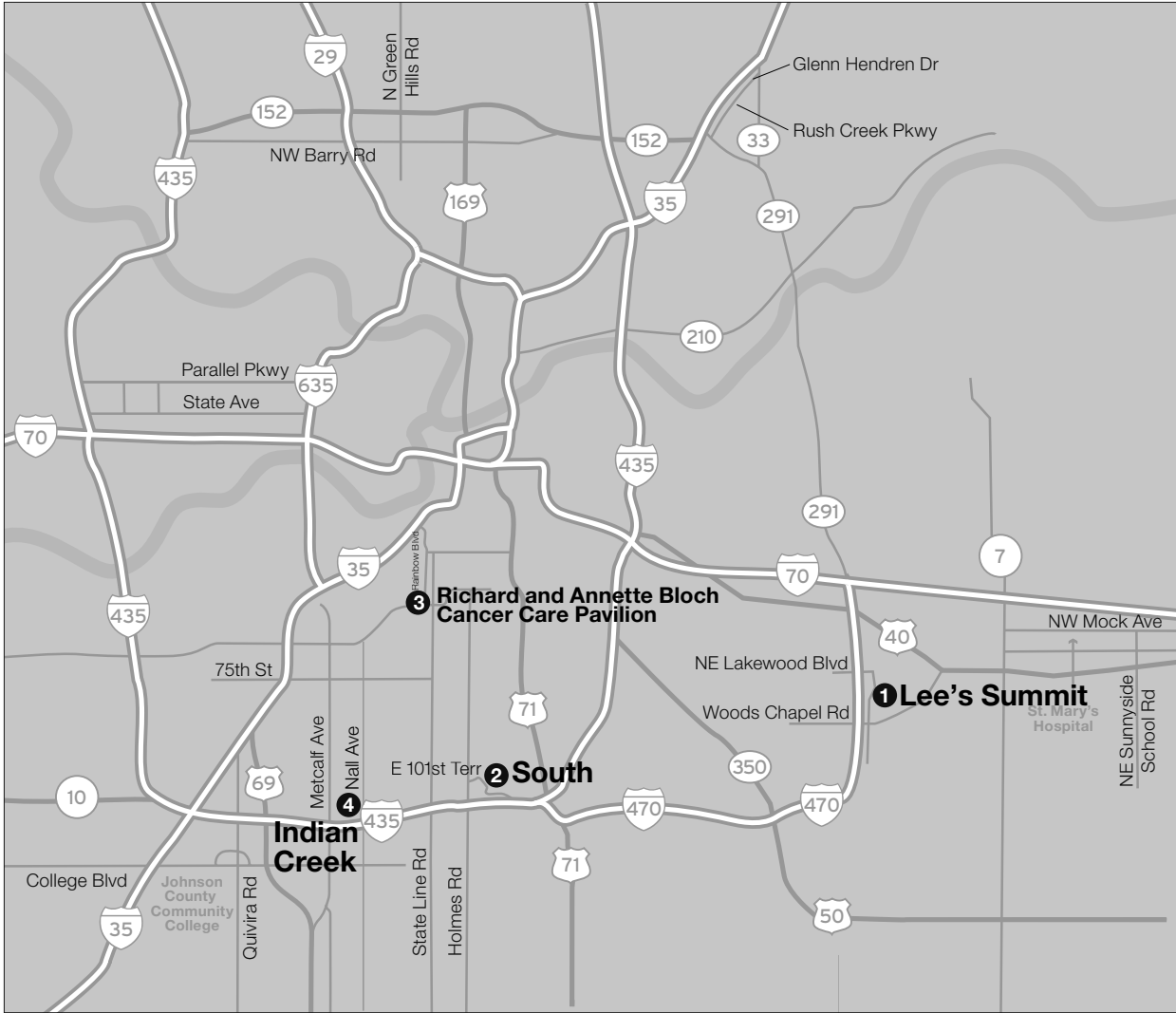
Preferred Clinic Location:

South []
1000 E. 101st Terrace
Kansas City, MO 64132
P - (816) 333-1326
F - (816) 333-0086

Lee's Summit []
4881 NE Goodview Circle
Lee's Summit, MO 64064
P - (816) 478-2050
F - (816) 478-6360

Westwood []
2330 Shawnee Mission Pkwy.
Westwood, KS 66205
P - (913) 588-1227
F - (913) 588-6765

Indian Creek []
10730 Nall Ave., Ste. 200
Overland Park, KS 66211
P - (913) 588-1227
F - (913) 945-9838



Lee's Summit ①

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 Main Fax: 816.478.6360
 Intake Fax: 816.841.1333
 Diagnostic Imaging Scheduling: 913.234.0482

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