LYMPHEDEMA / LIPEDEMA TREATMENT PLAN FORM

Lymph in Motion by Criselda White

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PATIENT INFORMATION

Patient Name:

_____

Date of Birth:

_____

Phone:

Address:

_____

_____

Insurance Provider:

_____

Member ID #:

_____

Referring Physician: _____

Date of Referral:

_____

DIAGNOSIS (ICD-10)

Diagnosis:

[ ] I89.0 - Lymphedema, unspecified

[ ] E88.20 - Lipedema

[ ] I97.2 - Post-mastectomy lymphedema

[ ] Q82.0 - Hereditary lymphedema

[ ] Other

CLINICAL ASSESSMENT

Primary Diagnosis:

[ ] Lymphedema

[ ] Lipedema

[ ] Mixed

Stage:

[ ] ILYMPHEDEMA / LIPEDEMA TREATMENT PLAN FORM

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[ ] II

[ ] III

Onset Date:

_____

Symptoms Present:

[ ] Swelling

[ ] Pain

[ ] Tightness

[ ] Heaviness

[ ] Numbness

[ ] Limited ROM

[ ] Fibrosis

[ ] Skin Changes

[ ] Recurrent Infections

Edema Location:

_____

Girth/Volume Measurements:

_____

Skin Condition:

[ ] Intact

[ ] Fibrotic

[ ] Hyperkeratosis

[ ] Discoloration

Mobility:

[ ] Normal

[ ] ImpairedLYMPHEDEMA / LIPEDEMA TREATMENT PLAN FORM

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Pain Scale (0-10): _____

Pitting Present:

[ ] Yes

[ ] No

Stemmer's Sign:

[ ] Positive

[ ] Negative

Functional Impact:

[ ] Difficulty standing/walking

[ ] Interference with ADLs

[ ] Unable to wear normal clothing/shoes

[ ] Emotional distress

PROGNOSIS

Prognosis:

[ ] Good

[ ] Fair

[ ] Guarded

TREATMENT PLAN

Treatment Frequency: _____

Session Duration:

_____

Projected Duration of Treatment: _____

Start Date:

_____

End Date (Projected): _____LYMPHEDEMA / LIPEDEMA TREATMENT PLAN FORM

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TREATMENT MODALITIES

Modalities:

[ ] Manual Lymphatic Drainage (MLD)

[ ] Compression Bandaging

[ ] Compression Garments

[ ] Skin Care Education

[ ] Fibrosis / Scar Tissue Management

[ ] Red Light Therapy

[ ] Vacuum Therapy / Endermologie

[ ] Lymphatic Exercise / ROM

[ ] Patient & Caregiver Education

[ ] Self-MLD Training

[ ] Kinesio Taping (Lymphatic Drainage technique)

MEASURABLE GOALS

Goal Measurable Outcome Timeline

_____

_____

_____

HOME PROGRAM / RECOMMENDATIONS

Recommendations:

[ ] Daily Self-MLD

[ ] Skin inspection

[ ] ElevationLYMPHEDEMA / LIPEDEMA TREATMENT PLAN FORM

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[ ] Compression wear compliance

[ ] Home exercise program

[ ] Follow-up with physician

[ ] Referral to DME provider

CERTIFICATION & SIGNATURES

Treating Therapist Name:_____

Signature: _____

Date:

_____

Referring Physician Name: _____

NPI #:

_____

Signature: _____

Date:

_____