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Patient Information Sheet

I, _____, a patient at the Lymphedema Treatment Center at the Virginia G. Piper Cancer Center at Scottsdale Healthcare hereby authorize the lymphedema therapist with the following:

1. Take photographs of me for identification purposes.
   Yes ☐ No ☐

2. Take photographs of appropriate parts of my body in order to provide supporting documentation of my medical condition. I understand that any photographs taken will be placed in and remain part of my medical records.
   Yes ☐ No ☐

3. Contact my referring medical doctor if needed.
   Yes ☐ No ☐

I understand that attending my scheduled appointments on a consistent basis is critical to my success in meeting my rehabilitation goals. If I miss three or more scheduled therapy visits, I understand that my referring physician will be notified and I may be discharged from therapy.
Yes ☐ No ☐

If you have an arm lymphedema, the therapist will need to work on the chest area in order to provide effective care. Are you willing to consent to the treatment of your chest area?
Yes ☐ No ☐ N/A ☐

If you have a leg lymphedema, the therapist will need to work on the upper medial thigh and buttock area in order to provide effective care. Are you willing to consent to the treatment of these areas?
Yes ☐ No ☐ N/A ☐

Patient signature:_____ Date:_____

Therapist signature:_____ Date:_____