

Please fax this form to us at 713.797.5988 and keep for your records.

Date: _____ Preferred Start Date: _____

Patient name: _____ Ph#: _____

Diagnosis: _____ DOB: _____

Precautions: _____

Weight Bearing Status: WBAT PWB NWB Other: _____

PHYSICAL THERAPY: (_____ visits per week for _____ weeks)

- Evaluation and treatment with emphasis on:
- | | | |
|---|---|---|
| <input type="checkbox"/> Therapeutic exercise | <input type="checkbox"/> Orthotics & prosthetic training & management | <input type="checkbox"/> Balance / Vestibular |
| <input type="checkbox"/> Gait training | <input type="checkbox"/> Modalities | <input type="checkbox"/> Developmental assessment |
| <input type="checkbox"/> Manual therapy | <input type="checkbox"/> Family training / Home program | <input type="checkbox"/> Balance Manager® |
| <input type="checkbox"/> Neuromuscular re-education | <input type="checkbox"/> LSVT® BIG | <input type="checkbox"/> Lokomat® |
| <input type="checkbox"/> Aquatic Therapy | | <input type="checkbox"/> Other: _____ |

OCCUPATIONAL THERAPY: (_____ visits per week for _____ weeks)

- Evaluation and treatment with emphasis on:
- | | | |
|---|--|--|
| <input type="checkbox"/> Therapeutic exercise | <input type="checkbox"/> Modalities | <input type="checkbox"/> Lymphedema |
| <input type="checkbox"/> Self care management / training | <input type="checkbox"/> Modified constraint induced therapy | <input type="checkbox"/> upper extremity |
| <input type="checkbox"/> Manual therapy | <input type="checkbox"/> Family training / Home program | <input type="checkbox"/> lower extremity |
| <input type="checkbox"/> Developmental assessment | <input type="checkbox"/> Functional tone management | <input type="checkbox"/> head and neck |
| <input type="checkbox"/> Neuromuscular re-education | <input type="checkbox"/> Energy Conservation / Work Simplification | |
| <input type="checkbox"/> Orthotics & prosthetic training / management | <input type="checkbox"/> LSVT® BIG | <input type="checkbox"/> Other: _____ |

SPEECH-LANGUAGE THERAPY: (_____ visits per week for _____ weeks)

- Evaluation and treatment of speech, language, voice and communication
- | | |
|--|---|
| <input type="checkbox"/> Evaluation and treatment of swallow dysfunction | <input type="checkbox"/> Lee Silverman Voice Treatment (LSVT®) Loud |
| <input type="checkbox"/> Modified barium swallow | <input type="checkbox"/> Cognitive re-training |
| <input type="checkbox"/> VitalStim® | <input type="checkbox"/> Other: _____ |

SEATING AND MOBILITY: TIRR Memorial Hermann at the Kirby Glen Center

Indicate additional therapies / services above, if needed.

- | | |
|---|---|
| <input type="checkbox"/> Evaluation and recommendation for Wheelchair/PMD*/Seating System | <input type="checkbox"/> SmartWheel® assessment/ Wheelchair propulsion assessment |
| <input type="checkbox"/> Delivery and fitting for Wheelchair/PMD*/Seating System | <input type="checkbox"/> Education re: Wheelchair/PMD*/ Seating System |
| <input type="checkbox"/> Pressure mapping assessment and recommendations | |
| <input type="checkbox"/> Training for Wheelchair/PMD*/Seating System recommended | |
| <input type="checkbox"/> Other: _____ | |
- *PMD - Power Mobility Device

CHALLENGE PROGRAM: TIRR Memorial Hermann at the Kirby Glen Center

Indicate additional therapies / services above, if needed.

- Evaluation and treatment
- | | |
|---|--|
| <input type="checkbox"/> Neuropsychology / Psychology | <input type="checkbox"/> Vocational rehabilitation |
| <input type="checkbox"/> Cognitive therapy | <input type="checkbox"/> School reintegration |

NEUROPSYCHOLOGY

- Neuropsychological Evaluation Psychological Evaluation Cognitive Rehabilitation Psychotherapy/Behavioral Management

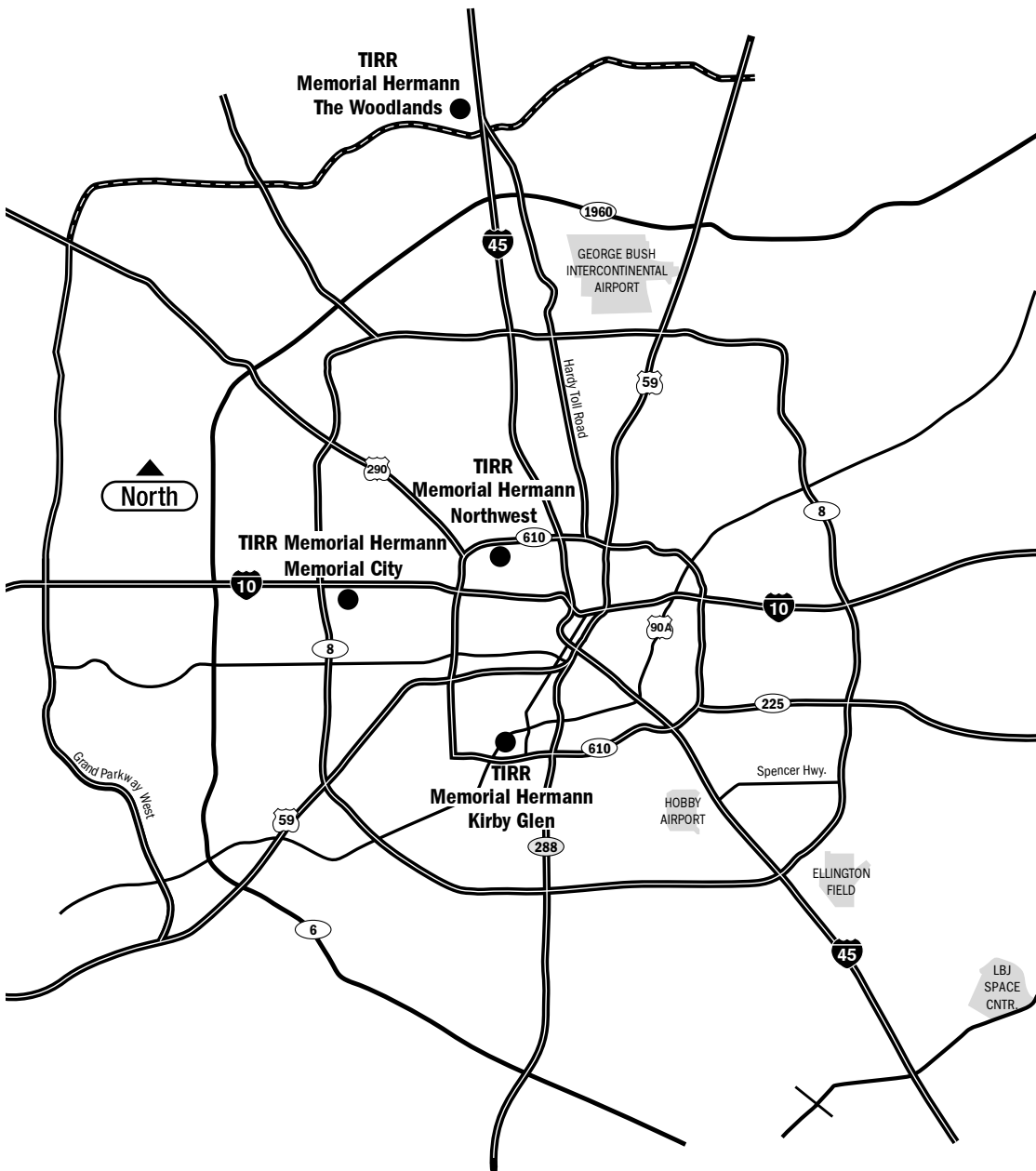
Specific Concerns: (indicate all applicable)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Baseline Assessment | <input type="checkbox"/> Follow-Up Evaluation | <input type="checkbox"/> Decision-Making | <input type="checkbox"/> Problem-Solving |
| <input type="checkbox"/> Return to School | <input type="checkbox"/> Return to Work | <input type="checkbox"/> Memory Impairment | |
| <input type="checkbox"/> Emotional Functioning | <input type="checkbox"/> Behavioral Issues | | |
| <input type="checkbox"/> Other: _____ | | | |

Comments: _____

Physician Signature _____ Last Name (Printed) _____ MSID# _____ Date _____ Time _____





**To make a referral or schedule an appointment for Outpatient Rehabilitation, please call
 1.800.44.REHAB (73422), 713.797.5942 or fax 713.797.5988**

**TIRR Memorial Hermann Outpatient
 Rehabilitation at the Kirby Glen Center**

2455 S. Braeswood
 Houston, TX 77030

Note: The TIRR Memorial Hermann
SEATING AND MOBILITY CLINIC
 can also be found at the
 Kirby Glen Center
 2453 S. Braeswood, Suite 210
 Houston, TX 77030

**TIRR Memorial Hermann
 Outpatient Rehabilitation-The Woodlands**

920 Medical Plaza Drive, Suite 270
 The Woodlands, TX 77380

**TIRR Memorial Hermann Outpatient
 Rehabilitation on the Campus of
 Memorial Hermann Memorial City**

929B N. Gessner, Suite 108
 Houston, TX 77024

**TIRR Memorial Hermann Outpatient
 Rehabilitation on the Campus of
 Memorial Hermann Northwest**

1635 North Loop West
 Houston, TX 77008