

**Memorial Hermann Rehabilitation Hospital - Katy
Orders for Outpatient Therapy Services**

Please fax this form to us at 713.797.5988 or email to
TIRRadmissionsintake@memorialhermann.org and keep for your records.

Date: _____ Preferred Start Date: _____

Patient name: _____ ICD Code: _____ Ph#: _____

Diagnosis: _____ DOB: _____

Weight Bearing Status: WBAT PWB NWB Other: _____

EVALUATION AND TREATMENT:		
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Speech-Language Therapy	<input type="checkbox"/> Rehabilitation Psychology/Neuropsychology
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Strength Unlimited (wellness program)	
PHYSICAL THERAPY:		
<input type="checkbox"/> Evaluation and treatment with emphasis on: (_____ visits per week for _____ weeks)	<input type="checkbox"/> Pulmonary dysfunction therapy	<input type="checkbox"/> Casting
<input type="checkbox"/> Vestibular	<input type="checkbox"/> Spasticity management	<input type="checkbox"/> Dry needling
<input type="checkbox"/> Orthotics & prosthetic training/management	<input type="checkbox"/> Energy conservation/Work simplification	<input type="checkbox"/> Concussion program
<input type="checkbox"/> Family training/Home program	<input type="checkbox"/> LSVT®BIG	<input type="checkbox"/> Post COVID Rehab
	<input type="checkbox"/> Prehabilitation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Electrical stimulation/FES	
OCCUPATIONAL THERAPY:		
<input type="checkbox"/> Evaluation and treatment with emphasis on: (_____ visits per week for _____ weeks)	<input type="checkbox"/> Orthotics & prosthetic training/management	<input type="checkbox"/> Casting
<input type="checkbox"/> Modified constraint induced therapy	<input type="checkbox"/> Family training/Home program	<input type="checkbox"/> ADL & IADL training
<input type="checkbox"/> Functional vision rehabilitation	<input type="checkbox"/> Spasticity management	<input type="checkbox"/> Dry needling
<input type="checkbox"/> Pre-driving assessment program	<input type="checkbox"/> Energy conservation/Work simplification	<input type="checkbox"/> Prehabilitation
<input type="checkbox"/> Lymphedema	<input type="checkbox"/> LSVT®BIG	<input type="checkbox"/> Post COVID Rehab
<input type="checkbox"/> Upper/Lower <input type="checkbox"/> Head/Neck	<input type="checkbox"/> Electrical stimulation/FES	<input type="checkbox"/> Other _____
SPEECH-LANGUAGE THERAPY:		
<input type="checkbox"/> Evaluation and treatment of speech, language, voice and communication (_____ visits per week for _____ weeks)	<input type="checkbox"/> VitalStim®	<input type="checkbox"/> Prehabilitation
<input type="checkbox"/> Evaluation and treatment of swallow dysfunction (_____ visits per week for _____ weeks)	<input type="checkbox"/> Lee Silverman Voice Treatment (LSVT®) Loud	<input type="checkbox"/> Concussion program
<input type="checkbox"/> Modified barium swallow	<input type="checkbox"/> Cognitive re-training	<input type="checkbox"/> Pediatric Feeding
	<input type="checkbox"/> Head and neck cancer treatment	<input type="checkbox"/> Post COVID Rehab
		<input type="checkbox"/> Other _____
EVALUATE FOR INPATIENT REHABILITATION ADMISSION:		
<i>(Please indicate any of the following concerns)</i>		
<input type="checkbox"/> Decline in the ability to ambulate	<input type="checkbox"/> There are frequent falls and increased weakness	
<input type="checkbox"/> Decline in the ability to perform activities of daily living	<input type="checkbox"/> There is a concern about declining function	
Is the patient receiving any therapy services currently (i.e. Home Health/Outpatient) <input type="checkbox"/> Yes <input type="checkbox"/> No		
If the patient is not receiving therapy currently, please order PT and OT evaluations to assist with this assessment. <input type="checkbox"/> Physical Therapy Evaluation <input type="checkbox"/> Occupational Therapy Evaluation		
STRENGTH UNLIMITED		
(Community -based wellness and recovery program)	<input type="checkbox"/> Able to exercise?	<input type="checkbox"/> Able to participate in a standing program?
REHABILITATION PSYCHOLOGY/NEUROPSYCHOLOGY		
<input type="checkbox"/> Neuropsychological Evaluation	Specific Concerns (indicate all applicable)	<input type="checkbox"/> Return to Work
	<input type="checkbox"/> Baseline Assessment	<input type="checkbox"/> Memory Impairment
	<input type="checkbox"/> Follow-Up Evaluation	<input type="checkbox"/> Emotional Functioning
	<input type="checkbox"/> Decision-Making	<input type="checkbox"/> Behavioral Issues
	<input type="checkbox"/> Problem-Solving	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Return to School	
Comments: _____		

Provider Signature _____ Print Name _____ NPI/MHHS ID. _____ Date _____ Time _____ AM PM Contact No. _____



Our facility is located in the second building, in the back of the campus.

Parking is free and conveniently located in a surface lot adjacent to the facility.

DIRECTIONS

Heading Westbound on I-10:

- Take 1-10 west toward Katy
- Take Exit 745 toward Mason Road
- Turn left at S. Mason Road
- Turn left onto Kingsland Blvd.
- Memorial Hermann Rehabilitation Hospital-Katy will be on your left

Heading Eastbound on I-10:

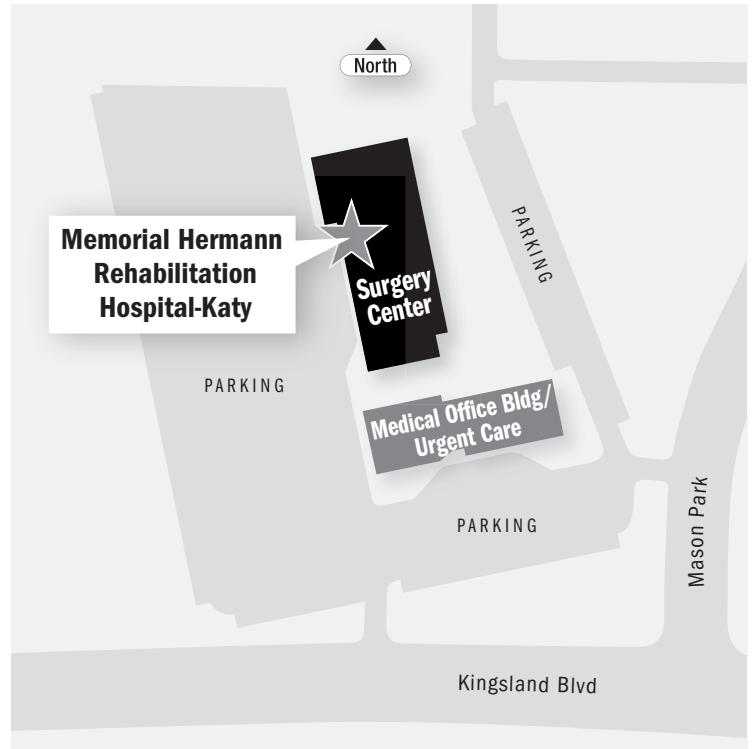
- Take 1-10 east toward Katy
- Take Exit 745 toward Mason Road
- Turn right at S. Mason Road
- Turn left onto Kingsland Blvd.
- Memorial Hermann Rehabilitation Hospital-Katy will be on your left

From Grand Parkway/Hwy 99:

- Take Grand Parkway/Hwy 99 north
- Exit at Kingsland Blvd.
- Turn right onto Kingsland and drive approximately 2 miles (past Mason Road)
- Memorial Hermann Rehabilitation Hospital-Katy will be on your left

Department Locator

DEPARTMENT	PHONE NUMBER
Imaging Center 1st Floor - Suite 102	281.579.5711
Outpatient Therapy 3rd Floor - Suite 304	281.579.5708
Inpatient Rehabilitation 2nd Floor	713.797.5942
Wound Care Center 3rd Floor	281.579.5542
Sleep Center 3rd Floor - Suite 302	281.579.5680
Neuropsychology 3rd Floor - Suite 303B	713.799.6990



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Rehabilitation
Hospital Katy

21720 Kingsland Blvd.
Katy, TX 77450

memorialhermann.org/katy-rehab/