Memorial Hermann Northeast
Lymphedema Referral Order Form

18960 North Memorial, Humble, Texas 77338 Phone: 281.540.6322 Fax:281.540.7107 Hours: 7:30AM - 4:30PM

Date of Referral:_____

Patient Name: _____ Date of Birth: _____

Diagnosis: _____

Please send a copy of insurance, face sheet and medical history.

Treatment Requested:
☐ **Occupational Therapy Evaluate and Treat**
☐ Manual Therapy
☐ Therapeutic Exercise
☐ Pre-Surgical Lymphedema Education
☐ Post Surgical Lymphedema Education
☐ Myofascial Release/Scar Tissue Mobilization

ICD Codes: Choose all that apply			
☐ Lymphedema, Post Mastectomy	197.2	☐ Thoracic Pain	M54.6
☐ Lymphedema, Other	189.0	☐ Disorder of Muscle and Fascia Unspecified	M62.9
☐ Joint Stiffness and Pain	M25.60 / M25.50	☐ Disorder of Soft Tissue Unspecified	M79.9
☐ Shoulder Pain and Stiffness	M25.519/M25.619	☐ Myalgia, Myositis Unspecified	M600.9/M79.1
☐ Cervical Neck Pain	M54.2	☐ Hereditary Lymphedema	Q82.0

Post Surgical Signs/Symptoms	
☐ Decreased Range of Motion	☐ Breast Edema
☐ Soft Tissue Adhesions	☐ Truncal Edema
☐ Lymphedema of the Breast/Chest Wall	☐ Axillary Web Syndrome
☐ Lymphedema of the Arm	☐ Other:

The prescription is valid for one month from the above date.

Providers Fax Number:_____

I certify that this prescribed therapy is medically necessary.

☐ I, referring provider, attest that I have discussed this referral with the patient, and the patient has provided consent to the sharing of their demographic and contact information with Memorial Hermann or its affiliated providers for the purposes related to this referral, including: (1) telephone calls and text messages regarding health care, including but not limited to scheduling, reminders, and medication refills; (2) email or mail communications regarding health care, including but not limited to scheduling, reminders, and medication referrals; and (3) other information regarding my health care, billing and health related services and benefits. I have instructed the patient if they wish to revoke this consent, they may contact Memorial Hermann at 713-222-CARE (2273) or opt out directly after receipt of communication.

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

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18420 (8/24)