TIRR MEMORIAL HERMANN Rehabilitation & Research

Cancer Rehabilitation Program Referral Form

Fax completed form to: 713-797-5988 or

email to: TIRRAdmissionsIntake@memorialhermann.org

PATIENT INFORMATION		
Date:	Preferred Start Date:	
Patient name:		DOB
ICD Code(s):	Phone:	
Diagnosis:		

REFERRAL	**LOCATIONS**
☐ Physical Therapy (PT) Evaluation and Treatment	☐ Kirby Glen (Medical Center)
☐ Occupational Therapy (OT) Evaluation and Treatment	☐ Sugar Land
☐ Lymphedema Management (OT Evaluation and Treatment)	☐ Memorial City
☐ Upper/Lower	☐ Rehabilitation Hospital – Katy
☐ Head/Neck	☐ Greater Heights
☐ Lymphedema Management (SLP Evaluation and Treatment)	☐ The Woodlands
☐ Head/Neck	☐ West University
☐ Vision Rehabilitation (OT Evaluation and Treatment)	☐ Closest to patient
☐ Prehabilitation	
☐ PT (Evaluation and Treatment)	
☐ OT (Evaluation and Treatment)	
☐ Speech Language Pathology Evaluation and Treatment	
☐ Neuropsychology Evaluation	
☐ Pre-Driving Assessment (OT Evaluation and Treatment)	
☐ Speech Language Pathology (Evaluation and Treatment)	
☐ Neuropsychology Evaluation	
☐ Seating and Mobility Evaluation	
☐ Challenge Program	
☐ Strength Unlimited (wellness program)	
☐ Consult: Physical Medicine and Rehabilitation (PMR)/Rehabilitation Physician	
☐ Other_____	

☐ 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.

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

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