

**Memorial Hermann Health System
Strength Unlimited Referral/Order Form**

Fax completed form to: 713-797-5988 Phone: 1-800-44REHAB (73422)

PATIENT INFORMATION		
Patient Name:		Phone Number:
Diagnosis:		Date of Birth:
Type of Referral: <input type="checkbox"/> New <input type="checkbox"/> Renewal		
General Programs	Specialty Programs	Equipment
<input type="checkbox"/> Adaptive Yoga	<input type="checkbox"/> Dysautonomia Exercise Program	<input type="checkbox"/> Body weight supported treadmill
<input type="checkbox"/> Aquatic Therapy	<input type="checkbox"/> Modified Constraint Induced Movement Therapy Program	<input type="checkbox"/> Functional Electrical Stimulation (FES)
<input type="checkbox"/> Limb Loss Exercise Program	<input type="checkbox"/> Oncology Exercise Program	<input type="checkbox"/> Indego
<input type="checkbox"/> Nutrition Coaching	<input type="checkbox"/> Parkinson's Disease Exercise Program	<input type="checkbox"/> Lokomat™
<input type="checkbox"/> Open Gym	<input type="checkbox"/> SCI ARM Exercise Program	<input type="checkbox"/> ReWalk™
<input type="checkbox"/> Personal Training		
Preferred location:		
<input type="checkbox"/> Kirby Glen <input type="checkbox"/> The Woodlands <input type="checkbox"/> Sugar Land <input type="checkbox"/> Memorial City <input type="checkbox"/> Rehabilitation Hospital-Katy <input type="checkbox"/> West Gray		
Special Precautions and/or Contraindications:		
<input type="checkbox"/> Patient cleared for bilateral lower extremity weight bearing.		
<input type="checkbox"/> Patient cleared for bilateral upper extremity activity range of motion and weight bearing.		
Cardiac Precautions: _____		
Others: _____		

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	Contact No.
				<input type="checkbox"/> AM <input type="checkbox"/> PM	

