Memorial Hermann Health System
Limb Loss Referral Inpatient and Outpatient Services

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

Date:_____ Preferred Start Date:_____

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

Diagnosis:_____ DOB: _____

PHYSICAL MEDICINE AND REHABILITATION

☐ **TIRR Outpatient Medical Clinic** (Limb Loss and Preservation)

EVALUATION AND TREATMENT:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech-Language Therapy ☐ Inpatient Rehabilitation Admission
☐ Rehabilitation Psychology/Neuropsychology

PHYSICAL THERAPY:

☐ Evaluation and Treatment with emphasis on: (_____ visits per week for ____ week(s)
☐ Balance Issues
☐ Candidacy Criteria
☐ Equipment Evaluation
☐ Family Training/Home Program
☐ Gait Training
☐ Orthotics and Prosthetic Training/Management
☐ Prehabilitation
☐ Strength/ROM
☐ Other_____

OCCUPATIONAL THERAPY:

☐ Evaluation and Treatment with emphasis on: (_____ visits per week for ____ week(s)
☐ ADL and IADL Training
☐ Energy Conservation/Work Simplification
☐ Equipment Evaluation
☐ Family Training/Home Program
☐ Lymphedema ☐ Upper/Lower ☐ Head/Neck
☐ Orthotics & Prosthetic Training/Management
☐ Overuse Issues
☐ Pre-Driving Assessment Program
☐ Prehabilitation
☐ Other_____

SPEECH-LANGUAGE THERAPY:

☐ Evaluation and Treatment with emphasis on: (_____ visits per week for ____ week(s)
☐ Cognitive Re-training
☐ Other_____

EVALUATE FOR INPATIENT REHABILITATION ADMISSION:

(Please indicate any of the following concerns)
☐ Concern About Declining Function
☐ Decline in The Ability to Ambulate/Mobilize
☐ Decline in The Ability to Perform Activities of Daily Living
☐ DM Management
☐ Equipment Assessment for Safety
☐ Family Training for Safe Discharge
☐ Frequent Falls and Increased Weakness
☐ Infection or High Risk
☐ Management of Comorbidities
☐ Medication Management (i.e. BP)
☐ Pain Control/Management
☐ Wound(s)

Is the patient receiving any therapy services currently (i.e. Home Health/Outpatient) ☐ Yes ☐ No

REHABILITATION PSYCHOLOGY/NEUROPSYCHOLOGY

☐ Neuropsychological Evaluation
☐ Psychotherapy/Behavioral Management
☐ Psychological Evaluation

Specific Concerns (indicate all applicable)
☐ Adjustment Disorder
☐ Altered Body Image
☐ Behavioral Issues
☐ Emotional Functioning
☐ Follow-Up Evaluation
☐ Memory Impairment
☐ Return to Work/School
☐ Other_____

Comments:

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

MEMORIAL HERMANN

Limb Loss Referral Inpatient and Outpatient Services