

Patient Name		Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Social Security #		Date of Birth	
Primary Phone	Alternate Phone		
Diagnosis		Diagnosis Code	
Procedure Performed		Date of Surgery	
<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Language Pathology			
<input type="checkbox"/> Evaluate and Treat <div style="display: flex; justify-content: space-between;"> <div> Visits/Week 1 2 3 4 5 <i>(Please circle)</i> </div> <div> Weeks of Treatment 1 2 3 4 6 8 <i>(Please circle)</i> </div> <div> OR _____ Number of Visits </div> </div>			
Special Instructions/Precautions/Relevant Findings:			
Weight Bearing Status: <input type="checkbox"/> NWB <input type="checkbox"/> PWB <input type="checkbox"/> WBAT <input type="checkbox"/> FWB			
Specific Protocol: _____			
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> AROM <input type="checkbox"/> AAROM <input type="checkbox"/> PROM <input type="checkbox"/> Custom Orthosis/Splint: _____ <input type="checkbox"/> Dry Needling <input type="checkbox"/> Electrical Stimulation <input type="checkbox"/> Fluidotherapy <input type="checkbox"/> Home Traction Unit </div> <div style="width: 33%;"> <input type="checkbox"/> Ice <input type="checkbox"/> Iontophoresis with Dexamethasone <input type="checkbox"/> Joint/Soft Tissue Mobilization <input type="checkbox"/> Moist Heat <input type="checkbox"/> Phonophoresis with Hydrocortisone <input type="checkbox"/> Strengthening <input type="checkbox"/> TENS </div> <div style="width: 33%;"> <input type="checkbox"/> Traction <input type="checkbox"/> Ultrasound <input type="checkbox"/> Gait Training <input type="checkbox"/> BIG/LOUD <input type="checkbox"/> Bioness – L300 Go <input type="checkbox"/> Fall Prevention </div> </div>			
I certify that the treatment is medically necessary.			
Physician's Name <i>(Please print)</i>			
Physician's Signature	Date/Time		

HOUSTON METHODIST NEUROLOGIC THERAPY LOCATION



INNER LOOP

1 Houston Methodist Outpatient Rehabilitation University Area

Neurologic Rehabilitation
1701 Sunset Blvd., Suite 6100
Houston, TX 77005
713.441.7406
Fax: 713.441.8348

SOUTHWEST

2 Houston Methodist Sugar Land Hospital Neuroscience & Spine Center

Physical Therapy, Occupational Therapy, Speech Therapy
16605 Southwest Fwy.
Medical Office Building 3, Suite 115
Sugar Land, TX 77479
281.313.2225
Fax: 281.276.0622

WEST

3 Houston Methodist West Outpatient Rehabilitation

18300 Katy Fwy., Suite 525
Houston, TX 77094
832.522.8200
Fax: 832.522.8201

NORTH

4 Houston Methodist Orthopedics and Sports Medicine – The Woodlands

17183 Interstate 45 S.
Medical Office Building 1, Suite 210
The Woodlands, TX 77385
936.270.2000
Fax: 936.271.9589

NORTHWEST

5 Houston Methodist Willowbrook Hospital Sports Medicine Rehabilitation Services

13802 Centerfield Dr., Suite 200
Houston, TX 77070
281.737.4325
Fax: 281.737.4326

EAST

6 Houston Methodist Baytown Hospital Outpatient Rehabilitation

1677 W. Baker Rd.
Baytown, TX 77521
Physical, Occupational, Hand, and Speech Therapy
281.420.6840
Fax: 281.420.6885

SOUTHEAST

7 Houston Methodist Orthopedics & Sports Medicine – Clear Lake

18100 Houston Methodist Dr.
Suite 100
Nassau Bay, TX 77058
281.333.8806
Fax: 281.333.8875

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