LYMPHEDEMA
THERAPY SPECIALISTS

PHYSICIAN / PROVIDER REFERRAL FORM

TEXAS MEDICAL CENTER / HOUSTON & SURROUNDING AREAS

CENTRAL SCHEDULING: PHONE: 713-497-5335 FAX: 833-891-3211

DATE:_____

PATIENT NAME: _____ **DOB:**_____ **PHONE:** _____

DIAGNOSIS:	**PLEASE CHECK ALL THAT APPLY:**
❑ Lymphedema (not elsewhere classified) ❑ Post Mastectomy Lymphedema Syndrome ❑ Hereditary Lymphedema ❑ Wound Care ❑ Other _____	❑ Upper Extremity ❑ Lower Extremity ❑ Head / Neck ❑ Chest ❑ Trunk ❑ Abdomen ❑ Genitals

- ❑ **EVALUATION & MANAGEMENT FOR LYMPHEDEMA**
- ❑ **COMPLETE LYMPHEDEMA THERAPY (CLT)**
- ❑ **MANUAL LYMPH DRAINAGE (MLD): Chest, Trunk, Abdomen, And Associated Pathways**
- ❑ **MULTI-LAYER COMPRESSION SYSTEM: Application to affected extremity**
- ❑ **IV ANTI-BIOTIC INFUSION**
- ❑ **SKIN & NAIL CARE WITH PRECAUTIONS AND WRITTEN INSTRUCTIONS**
- ❑ **THERAPEUTIC (ROM) EXERCISE WITH WRITTEN INSTRUCTIONS**
- ❑ **PNEUMATIC DEVICE THERAPY**
- ❑ **PATIENT IS HOMEBOUND / HOME EVALUATION**
- ❑ **WOUND CARE**

EQUIPMENT & SUPPLIES:

- ❑ **PNEUMATIC COMPRESSION DEVICE:**
  - ❑ Segmental home model with or without calibrated gradient pressure.

I CERTIFY THAT THE ABOVE ORDERS ARE MEDICALLY NECESSARY AND APPROPRIATE FOR THIS PATIENT.

LCMP SIGNATURE_____ **DATE:**_____ **NPI**_____

LCMP NAME _____**PHONE**_____**FAX**_____

ADDRESS: _____**CITY**_____**STATE**_____**ZIP**_____

Medical Center Location: 9230 Kirby Drive, Suite 100, Houston, TX 77054
Katy Location: 705 S. Fry Rd. Suite 100, Katy, TX 77450
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