 

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:

**PLEASE CHECK ALL THAT APPLY:**

❏ Upper Extremity

❏ Lower Extremity

❏ Head / Neck

❏ Chest

❏ Trunk

❏ Abdomen

❏ Genitals

**DIAGNOSIS**:

❏ Lymphedema (not elsewhere classified)

❏ Post Mastectomy Lymphedema Syndrome

❏ Hereditary Lymphedema

❏ Wound Care

❏ Other

❏ 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

**Phone: 713-497-5335**

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