



PHYSICIAN / PROVIDER REFERRAL FORM

Texas Medical Center / Katy / Conroe-Woodlands / Clear Lake

CENTRAL SCHEDULING: Phone: 713-497-5335 Fax: 833-891-3211

Date: _____

Patient Name: _____ **DOB:** _____ **Phone:** _____

DIAGNOSIS:

- ☐ Lymphedema (not elsewhere classified)
- ☐ Post Mastectomy Lymphedema Syndrome
- ☐ Hereditary Lymphedema
- ☐ Wound Care
- ☐ Other _____

PLEASE CHECK ALL THAT APPLY:

- ☐ Upper Extremity
- ☐ Head / Neck
- ☐ Trunk
- ☐ Genitals
- ☐ Lower Extremity
- ☐ Chest
- ☐ Abdomen

REQUESTED TREATMENTS AND SERVICES:

- ☐ Evaluation & Management for Lymphedema
- ☐ Complex Decongestive Physiotherapy
- ☐ Wound Care
- ☐ IV Antibiotic Infusion

DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES:

- ☐ Pneumatic Compression Device for Home Care
- ☐ Compression Wear

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

LCMP Signature: _____ Date: _____ NPI: _____

LCMP Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Medical Center/Houston: 2385 W. Belfort Ave., Suite 100, Houston, TX 77054

Katy: 707 S. Fry Road, Suite 255, Katy, TX 77450

Conroe - Woodlands: 1501 River Pointe Drive, Suite 100, Conroe, TX 77304

Clear Lake: 1045 Gemini St., Suite 150, Houston, TX 77058

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