STROWMATT REHABILITATION SERVICES
Your Road to Independence
10690 SHADOW WOOD DRIVE, SUITE 113
HOUSTON, TX 77043
PHONE (713) 722-0667 FAX (713) 722-0669
E-mail: strowmattrehabservices@gmail.com
Web site: driverrehabservices.com

PHYSICIAN'S REFERRAL

Referral Date:_____

Name: _____ Date of Birth:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip Code:_____

Email:_____ Gender: Male_____ Female_____

MEDICAL DIAGNOSIS Date of Onset:_____
TBI_____ SCI_____ Level_____
CVA_____ Left Hemiparesis_____ Right Hemiparesis_____
Other:_____

Diagnosis Code(s):_____

Mobility Status:_____ Height:_____ Weight:_____

Ambulatory_____ Cane_____ Wheelchair: Manual_____ Power_____ Walker_____

Transfer status_____

Driver License/Permit Number:_____ Expiration Date:_____

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____1. Motor Vehicle Operation Evaluation/Training--From A Medical Standpoint, This Patient Is Capable Of Participating In A Program To Evaluate Motor Vehicle Operation Capacity.

____2. Driving Evaluation Following An Acute Injury—Evaluation Of A Patient's Capacity To Return To Motor Vehicle Operation Following One or More Of The Following Conditions: Fractured Limbs, Sprained Joints, Whiplash Injury, Lengthy Illness (Poor Endurance), Etc.

☐ *PLEASE CHECK IF YOU WANT COPY OF REPORT FAXED TO YOU*

Physician's Signature:_____ Date:_____

Print Physician's Name:_____ Phone:_____

Physician's Address:_____ Fax:_____

FUNDING SOURCE - YOU MUST SELECT ONE OF THE OPTIONS BELOW:

A) Self Pay _____ SRS DOES NOT FILE HEALTH INSURANCE. Private health insurance consumers require payment at time of services before patient files for reimbursement.

B) Worker's Comp _____ For Worker's Comp, Trusts and VA, REQUIRE PRE-PAYMENT
OR Trust *Case Manager:*_____ *Company:*_____
*Email:*_____ *Phone:*_____

C) TWC/HCIL/ILS _____ Vocational Rehab 3rd Party. We will send a quote to your counselor
LRS/OK-VOC *Counselor:* _____ *Phone:* _____
(Circle One) *Email:*_____ *Field Office:*_____