



STROMMATT 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: strommattrehabservices@gmail.com

Web site: driverrehabservices.com

PROGRAM 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: _____

___ 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: _____