STROWMATT REHABILITATION SERVICES
Your Road to Independence
11020 KATY FREEWAY, SUITE 217
HOUSTON, TX 77043
PHONE (713) 722-0667 FAX (713) 722-0669
E-mail: strowmattrehabservices@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:**_____
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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 requires payment at time of services before filing for reimbursement.

B) **Worker's Comp** _____For Worker's comp and VA, **SRS REQUIRES PRE-PAYMENT**
*Case Manager:*_____ *Phone:* _____
*Email:*_____*Fax:* _____

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:*_____