



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: 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 _____ Incomplete?? _____ Yes _____ No

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 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: _____