Memorial Hermann Health System
TIRR Memorial Hermann and the Memorial Hermann Rehabilitation Network
Referrals for Direct Admissions from Home

Please e-mail this form/order and other information requested to us at
TIRRAdmissionsIntake@memorialhermann.org
Or E-fax 281-365-0046

Date: _____

Patient Information				
First Name	Middle Name	Last Name	Previous Name	Preferred Name
Address		City, State		Zip Code
Home Phone	Mobile Phone	Work Phone	Email ☐ No Email	
Emergency Contact:			Phone Number:	
Diagnosis:			Is the patient currently receiving any therapy services? (i.e. Home Health / Outpatient) ☐ Yes ☐ No - **Please fill out referral below**	
ICD Code:				

Referral	
Referring Physician:	Has the patient been seen by a physician within the last 30 days? ☐ Yes: Date: _____ Please include most recent physician visit note(s) ☐ No
Physician Office Contact Number:	
Comments/Precautions:	

Insurance Information and Medication List

- ☐ Send front and back of insurance card for financial team to verify inpatient rehab benefits
- ☐ Send medication list if available

Outpatient Therapy Referral - Evaluation and Treatment (indicate if needed for evaluation)

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy

Home Health Referral (If Homebound) - Evaluation and Treatment (indicate if needed for evaluation)

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy

_____	_____	_____	_____	☐ AM ☐ PM	_____
Signature	**Physician Print Name**	**NPI/MHHS ID.**	**Date**	**Time**	**Contact No.**

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