MEMORIAL HERMANN
Texas Medical Center

Memorial Herman Texas Medical Center Houston, TX 77030
OUTPATIENT THERAPY DEPARTMENT
Hand/ Burn Clinic: Office: 713-704-1545 | Fax: 713-704-9940
Speech/PT/OT Pediatric clinic: Office: 713-704-2960 | Fax: 713-704-5024

Patient: _____ Date: _____/_____/_____

Diagnosis: _____ DOI/S: _____/_____/_____

Precautions: _____

Referring Provider: _____ Phone: _____ Fax: _____

Begin Therapy: ☐ Today ☐ This week ☐ _____days post op ☐ _____ weeks post op
Integrity of Reconstruction: ☐ Secure /good ☐ Moderate/fair ☐ Tenuous/poor

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OCCUPATIONAL THERAPY: (_____ visit per week for _____ weeks)

☐ Evaluation and Treatment with emphasis on:

☐ Shoulder/Elbow/Forearm	☐ MP/PIP/DIP	☐ Thumb CMC/MP/IP	☐ Intrinsics	☐ Extrinsics
☐ Wrist	☐ Wound Care	☐ Lymphedema: UE/LE	☐ Burn Rehab	☐ Strengthening
☐ Patient/family training	☐ Sensory Re-ed	☐ Motor Re-ed	☐ Modalities	☐ ADL's
☐ DME_____	☐ Serial Casting	☐ Orthotic Fabrication		
☐ Scar Management	☐ ROM_____	☐ Other: _____		

PHYSICAL THERAPY: (_____ visit per week for _____ weeks)

☐ Evaluation and Treatment with emphasis on:

☐ Burn Rehab	☐ Wound Care	☐ Hydrotherapy	☐ ROM	☐ Strengthening
☐ Gait training	☐ Patient ed	☐ Sensory Re-ed	☐ Motor Re-ed	
☐ Modalities	☐ Family Training	☐ Wheelchair/DME eval and/or Fitting		
☐ Other: _____				

SPEECH-LANGUAGE THERAPY: (_____ visit per week for _____ weeks)

☐ Evaluation and Treatment with emphasis on:

☐ Feeding	☐ Voice disorders	☐ Language	☐ Articulation
☐ Resonance	☐ Laringectomized pts	☐ FEES (Fiberoptic Endoscopic evaluation of Swallow)	
☐ Other:_____			

Specifics Comments/Instructions: _____

_____

_____

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

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Outpatient
Clinic Script

66699 (7/23)