REFERRAL FOR PHYSICAL OR OCCUPATIONAL THERAPY

STAR THERAPY SERVICES

www.starhoustonphysicaltherapy.com

BRIDGELAND
21211 FM 529 Road, Unit 102
Cypress, TX 77433
Phone: (832) 295-0650 Fax: (832) 295-0651

CINCO RANCH
2840 Commercial Ctr Blvd Suite 103
Katy, TX 77494
Phone: (281) 693-1063 Fax: (281) 693-1081

COPPERFIELD
8955 Highway 6 North, Suite 190
Houston, TX 77095
Phone: (832) 593-8600 Fax: (832) 593-8601

CY-FAIR
11242 FM 1960 Rd West, Suite 104
Houston, TX 77065
Phone: (281) 469-8163 Fax: (281) 469-5559

FAIRFIELD
15201 Mason Road, Suite 800
Cypress, TX 77433
Phone: (713) 609-9224 Fax: (713) 324-7751

FULSHEAR
29615 FM 1093. Suite 2
Fulshear, TX 77441
Phone: (281) 533-0507 Fax: (281) 533-0521

KATY
21707 Kingsland Blvd., Suite 101
Katy, TX 77450
Phone: (281) 398-8235 Fax: (281) 398-8246

LAKEWOOD
13215 Grant Road, Suite 900
Cypress, TX 77429
Phone: (832) 220-9211 Fax: (832) 610-2354

Patient Name: _____ Date: _____

Patient Phone: (H) _____ (W) _____ (C) _____ DOB: _____

Worker's Compensation ☐ YES ☐ NO Adjuster / Case Manager: _____

Diagnosis: _____

Precautions/Contraindications: _____

Frequency: _____ Per Week For _____ Weeks

☐ EVALUATE & TREAT ☐ CONTINUE THERAPY

TREATMENT

- Passive Range of Motion
- Active Assisted ROM
- Active Range of Motion
- Strengthening
- Home Exercise Program
- Joint Mobilization
- Myofascial Release
- Functional Training
- Gait Training
- Proprioceptive Training
- Postural Re-Education
- Body Mechanics Training
- Cervical/Lumbar Traction
- Other: _____

SPECIALTY PROGRAMS

- Back School
- Pre-Op Program
- Home TENS Unit
- Home Traction Unit
- Custom Splints *(Cy-Fair)*
- Fall Prevention
- Cancer Related Fatigue
- Balance & Fall Prevention
- Work Conditioning

MODALITIES

- Per Therapist Discretion
- Other _____

GOALS

- Increase ROM
- Increase Strength
- Improve Function
- Increase Mobility
- Decrease Pain
- Decrease Edema
- Functional Training
- Increase Understanding

ADDITIONAL COMMENTS _____

I certify the above services are required by this patient on an outpatient basis

Physician Name: _____

Physician Signature: _____ Date: _____ NPI _____

DO NOT EMAIL PRESCRIPTION The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

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Certified Hand Therapy

Star Therapy Services is a group of progressive outpatient physical therapy clinics that offer a multitude of rehabilitative options to the physicians in our medical community. We specialize in land based treatment interventions for the general orthopedic, geriatric, post-operative, and sports medicine patient. Our treatment methods emphasize one-on-one patient provider interaction and focus on therapeutic exercise, neuromuscular re-education, manual therapy, modalities, and patient education.

JUST A REMINDER
- Please bring this referral slip with you on your first visit.
- Please arrive 15 minutes before your scheduled appointment to complete any necessary paperwork.

WHAT TO WEAR
- Please bring comfortable clothing and sneakers including T-shirts or tank tops and shorts or sweatpants.
- If are coming for hand therapy please wear short sleeves.

WHAT TO BRING
(Insurance Forms)
- Referral slip from your doctor.
- PPO/HMO information.
- For worker's comp claim, bring employer information number.