



Injury Center of Houston

A Subsidiary of Injury Specialist Associates, P.A.

www.injurycenterhouston.com

Fax to: 713-771-1876

Patient Name: _____ **Date:** _____

Social Security #: _____ **D.O.B.:** _____

Diagnosis: _____

Evaluate and Treat Impairment Rating Physical Therapy

Functional Capacity Evaluation (FCE) Manipulation Under Anesthesia (MUA) Nerve Conduction Velocity Testing (NCV/EMG)

Therapy Procedures:	Modalities:	Structured Programs:
<input type="checkbox"/> Gait training <input type="checkbox"/> Home exercise program <input type="checkbox"/> Manual therapy <input type="checkbox"/> Myofascial release <input type="checkbox"/> Massage <input type="checkbox"/> Joint mobilization <input type="checkbox"/> Spinal Manipulation/Adjustment <input type="checkbox"/> Mobility exercises <input type="checkbox"/> AAROM <input type="checkbox"/> AROM <input type="checkbox"/> PROM <input type="checkbox"/> Neuromuscular re-education <input type="checkbox"/> Balance <input type="checkbox"/> Coordination <input type="checkbox"/> Stabilization Exercise <input type="checkbox"/> Strengthening Exercises <input type="checkbox"/> Isometrics/Isotonic <input type="checkbox"/> Progressive Resistive Exercises <input type="checkbox"/> Circuit Strength Training	<input type="checkbox"/> Electric Stimulation <input type="checkbox"/> Interferential <input type="checkbox"/> Hot/Cold Therapy <input type="checkbox"/> Paraffin Bath <input type="checkbox"/> Ultrasound <input type="checkbox"/> Traction-mechanical <input type="checkbox"/> Phonophoresis <input type="checkbox"/> Cold Laser/Light Therapy <input type="checkbox"/> DTS Spinal Decompression <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> As Needed (PRN)	<input type="checkbox"/> Work Hardening <input type="checkbox"/> Work Conditioning <input type="checkbox"/> Chronic Pain Management (Behavioral) <input type="checkbox"/> Aquatic Therapy
		Therapy Goals:
		<input type="checkbox"/> Decrease pain <input type="checkbox"/> Improve Functional Capacity <input type="checkbox"/> Decrease Inflammation <input type="checkbox"/> Increase mobility <input type="checkbox"/> Increase strength <input type="checkbox"/> Increase stabilization <input type="checkbox"/> Other _____
		Treatment Frequency: 1 2 3 4 5 (visits/Wk)
		Treatment Duration: 1 2 3 4 5 6 (Wks)
		<input type="checkbox"/> Per therapist discretion

Comments/Special Requests: _____

In making this referral, physician certifies that the prescribed treatment is a medical necessity.

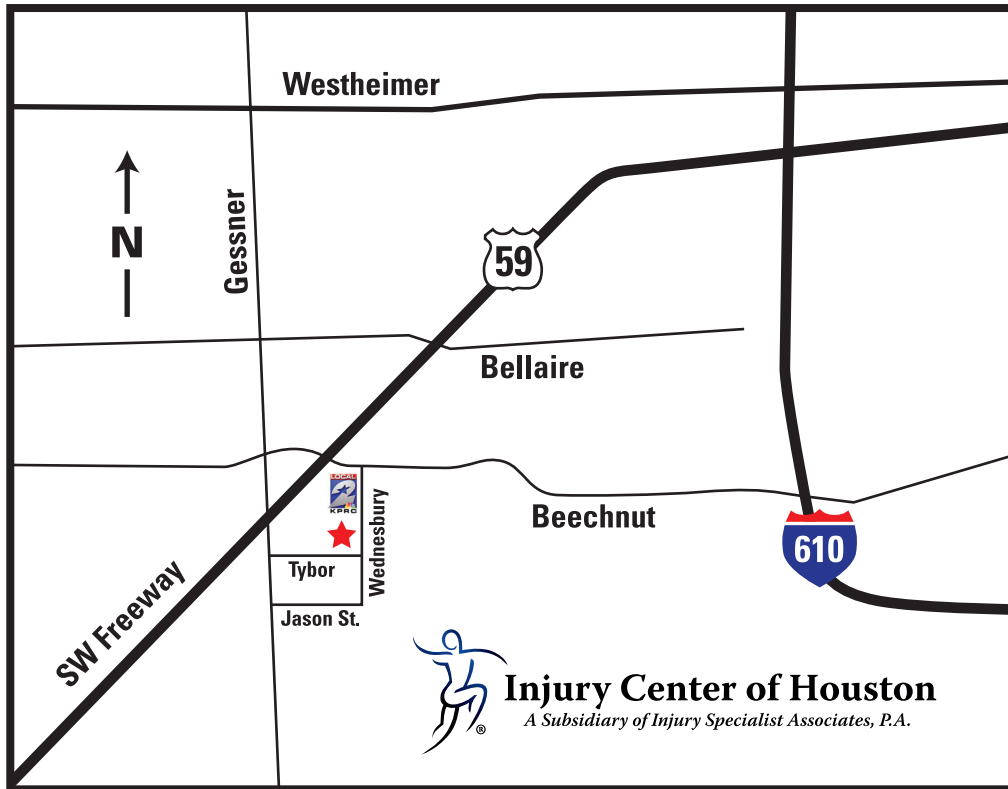
Referring Doctor: _____

SIGNATURE: _____ DATE: _____

Please fax this request with the following information to 713-771-1876:

• Patient demographics • Insurance information • Diagnostic information • Recent office note

A.R.S. Prasad, MD • Cheng Lee, DC • Paul Raymond, DC
Marvin Chang, MD • Y. Bryan Lee, DPM • Junpei Yamaji, DC
8200 Wednesbury, Suite 210
Houston, Texas 77074
Phone: 713-771-2225 Fax: 713-771-1876



Directions:

From 610:

- 1- Go Highway 59 southbound
- 2- Exit Beechnut/Gessner
- 3- Turn left on Beechnut
- 4- Make an immediate right turn at the first street (Wednesbury Lane)
- 5- We are the 3rd building on the right side (right after the NBC-KPRC Channel 2 building)

From Beltway 8 (Sam Houston Tollway)

- 1- Go Highway 59 northbound
- 2- Exit Beechnut/Gessner
- 3- Turn right on Beechnut
- 4- Make an immediate right turn at the first street (Wednesbury Lane)
- 5- We are the 3rd building on the right side (right after the NBC-KPRC Channel 2 building)