HOUSTON Methodist®
LEADING MEDICINE

CENTER FOR RESTORATIVE PELVIC MEDICINE
6560 Fannin St.
Surlock Tower Suite 2100
Houston, Texas 77030
Phone: 713.441.9220 Fax: 713.441.0248

PHYSICAL THERAPY REFERRAL FORM

To ensure clear communication for the treatment of CRPM patients, please complete this form and fax to the clinic coordinator. The clinic coordinator will assist patients in scheduling appointments with the other CRPM members. Please include any medical records when referring patients. For purposes of record keeping, all patients should be registered with this office. Thank you for your assistance in treating patients.

PATIENT INFORMATION:

NAME LAST	FIRST	MI	DOB MM/DD/YYYY
ADDRESS (OR ATTACH DEMOGRAPHIC SHEET)	HOME PHONE	WORK PHONE	CELL PHONE
INSURANCE	ID	GROUP	CUST SVC #

REFERRAL FOR:

☐ Evaluation and Treatment for Pelvic Muscle Rehabilitation & Physical Therapy as indicated

MEDICAL DIAGNOSIS:

REASON FOR REFERRAL:

(Note: This is a reference list intended for use as a guideline to assist in identifying the reason for referral and is not an all-inclusive list.)

☐ Chronic Pelvic Pain	☐ Diastasis Recti	☐ Painful Bladder
☐ Sciatica	☐ Pain in Pelvis / Thigh	☐ Fecal Incontinence
☐ Lower Back Pain	☐ Dyspareunia	☐ Urinary Incontinence
☐ Pubic Symphysis Pain	☐ Vulvodynia / Vestibulitis	☐ Urinary Urgency
☐ Difficulty Sitting	☐ Vaginismus	☐ Urinary Frequency
☐ Difficulty Walking	☐ Erectile Dysfunction	☐ Pudendal Nerve Pain
☐ SIJ Pain	☐ Muscle Weakness	☐ Prolapse
☐ Coccyx / Tailbone Pain	☐ Muscle Pain	☐ Constipation
☐ Lymphedema	☐ Muscle Spasms	☐ Groin Pain
☐ Incomplete Voiding	☐ Rectal Pain	☐ Other (Please Specify)

Additional Comments / Precautions:

Is patient post operative? Yes or No	If so, what procedure was performed?

PLEASE FAX THIS FORM TO: 713.441.0248 We will contact the patient the same day or the next working day

PHYSICIAN'S NAME	PHONE	FAX
PHYSICIAN'S SIGNATURE	OFFICE CONTACT PERSON	DATE/TIME