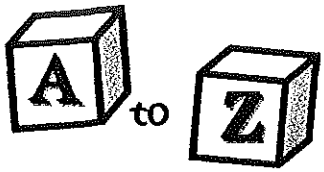

Pediatric Therapy

REFERRAL FORM - PHYSICIAN'S PRESCRIPTION

FAX: 1.866.497.2746 (Toll-Free) PHONE: 817.727.2869

Please use this form to start your patient's therapy services with **A to Z Pediatric Therapy**

PATIENT INFORMATION

PATIENT'S NAME _____ DATE OF BIRTH: ___/___/_____

PARENT/CAREGIVER'S NAME _____

PRIMARY LANGUAGE SPOKEN IN THE HOME: ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____

ADDRESS _____ APARTMENT _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____)_____ OTHER PHONE (_____)_____

MEDICAID # _____ MEDICAID HMO? _____ YES _____ NO TYPE _____

OTHER INSURANCE? _____ YES _____ NO IF YES, NAME OF INSURANCE _____

POLICY HOLDER NAME _____ DOB: ___/___/_____ ID # _____

INSURANCE POLICY GROUP # _____ INSURANCE PHONE # _____

CHIEF COMPLAINT OR DIAGNOSIS _____

DIAGNOSIS & ICD-9 _____ ONSET DATE _____/_____/_____

DIAGNOSIS & ICD-9 _____ ONSET DATE _____/_____/_____

(PLEASE SEND ADDITIONAL DIAGNOSES OR INSTRUCTIONS ON SEPARATE SHEET IF NECESSARY)

PHYSICIAN INFORMATION

PHYSICIAN NAME _____ CLINIC NAME _____

ADDRESS _____ CITY, STATE, ZIP _____

PHONE (_____)_____ FAX (_____)_____

RECOMMENDED THERAPY

SPEECH/LANGUAGE THERAPY	OCCUPATIONAL THERAPY	PHYSICAL THERAPY
____ EVALUATION ONLY	____ EVALUATION ONLY	____ EVALUATION ONLY
____ EVALUATION & TREATMENT	____ EVALUATION & TREATMENT	____ EVALUATION & TREATMENT
____ OTHER _____	____ OTHER _____	____ OTHER _____

PHYSICIAN'S SIGNATURE _____ **DATE** _____

PLEASE SIGN AND DATE SO THAT WE CAN START YOUR PATIENT'S CARE IMMEDIATELY