



REFERRAL FORM - PHYSICIAN'S PRESCRIPTION

FAX: 1.866.497.2746 (Toll-Free) PHONE: 817.727.2869

Pediatric Therapy

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

- EVALUATION ONLY
EVALUATION & TREATMENT
OTHER

OCCUPATIONAL THERAPY

- EVALUATION ONLY
EVALUATION & TREATMENT
OTHER

PHYSICAL THERAPY

- EVALUATION ONLY
EVALUATION & TREATMENT
OTHER

PHYSICIAN'S SIGNATURE DATE

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

(Confidential Information)

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A to Z PEDIATRIC THERAPY: PO Box 1972, Keller, TX 76244