PHYSICIAN PRESCRIPTION/REFERRAL FORM

FAX 877.658.2520 | PHONE: 877.688.2520

PATIENT INFORMATION

Patient Name: _____ DOB _____ /_____ / _____

Parent/Caregiver Name: _____

Address: _____ Apartment: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Other Phone: _____

Medicaid #: _____ Medicaid HMO? ___Yes ___No Plan Name: _____

Other Insurance? ___ Yes ___ No If yes, name of insurance Company: _____

Policy Holder Name: _____ ID# _____

Insurance Policy Group # _____ Insurance Phone: _____

Diagnosis and ICD 10 Code: _____ Onset Date: _____

Diagnosis and ICD 10 Code: _____ Onset Date: _____

(Please send additional diagnoses or instruction on a second referral sheet if necessary)

Special Instructions/Precautions: _____

PHYSICIAN INFORMATION

Physician Name: _____ Clinic Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

If form is not completed by physician, please provide the information below:

Name: _____ Organization _____ Phone _____

How did you hear about us? _____

RECOMMENDED THERAPY

PHYSICAL THERAPY	OCCUPATIONAL THERAPY	SPEECH THERAPY
_____Evaluation and treatment *(1-3 times/week for up to 180 days)* Include Well Child Check	_____Evaluation and treatment *(1-3 times/week for up to 180 days)* Include Well Child Check	_____Evaluation and treatment *(1-3 times/week for up to 180 days)* Include Well Child Check

If high-risk infant, please check box: ☐

High Risk Infant is *< 18 months old with a history of prematurity/low birth weight, birth trauma or prolonged hospitalization* ***AND*** *medical dx that may result in delays in neurodevelopmental functioning.*

If feeding referral please check box: ☐

Physician Signature: _____ Date: _____/_____ / _____

By signing this Prescription/referral Form, I am attesting that the Texas Health Steps checkup is current OR that a developmental screening has been performed within the last 60 days.