



PHYSICIAN PRESCRIPTION/REFERRAL FORM
FAX 877.658.2520 | PHONE: 877.688.2520 | WWW.T2000.COM

Please use this form to send referral or prescription information to THERAPY 2000

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 only | ____ Evaluation only | ____ Evaluation only |
| ____ Evaluation and treatment | ____ Evaluation and treatment | ____ Evaluation and treatment |
| <i>(1-3 times/week for up to 180 days)</i> | <i>(1-3 times/week for up to 180 days)</i> | <i>(1-3 times/week for up to 180 days)</i> |
| ____ Other _____ | ____ Other _____ | ____ Other _____ |

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.

(Confidential Information)

Unless otherwise indicated or obvious by the nature of this transmittal, the information contained in this FAX message is privileged and confidential, intended for the use of the designated recipient (or the employee or agent responsible to deliver to the designated recipient). You are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately via toll-free call to 877.688.2520 or a collect call to 214.467.9787.