



# 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 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)

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