



PHYSICIAN PRESCRIPTION/REFERRAL FORM

FAX 210.457.2004 | PHONE: 210.457.2000

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 and treatment <i>(1-3 times/week for up to 180 days)</i> Include Well Child Check	_____ Evaluation and treatment <i>(1-3 times/week for up to 180 days)</i> Include Well Child Check	_____ Evaluation and treatment <i>(1-3 times/week for up to 180 days)</i> 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.

(Confidential Information)

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