texaskids
HOME THERAPY & NURSING

Referral/Order Form

Office Phone: (210) 360-1662
216 E. Blanco Suite #101
Please fax referral to:
(210) 568-2228

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ Zip code: _____

Parent/Guardian: _____ Home Phone: _____ Cell: _____

Language: ☐ English ☐ Spanish ☐ Other: _____

Insurance

Medicaid/CHIP

Member ID#: _____

☐ Aetna/CHIP ☐ BCBS Medicaid ☐ Community First ☐ Molina ☐ Superior ☐ Traditional

☐ Other Insurance: _____ Policy#: _____ Group#: _____

Insurance ID: _____ Policy Holder DOB: _____

Referral Request

Type of Request:

☐ Speech Therapy
☐ Occupational Therapy
☐ Physical Therapy
☐ Private Duty Nursing

Please Attach Medical History if Possible

Diagnosis Codes:

1.) _____
2.) _____
3.) _____
4.) _____

Preferred Time of Therapy: ☐ Daytime ☐ After School ☐ Daycare/School

If your child attends school, when are they home? _____

Has this patient been seen for therapy by another company within the last 12 months? ☐ Yes ☐ No

Referring Physician

Referral Source: _____

Physician Name: _____ NPI: _____

Phone#: _____ Fax#: _____

☐ MD/Parent decline referral to ECI

Physician Signature: X _____ Date: X _____

PLEASE SIGN AND RETURN AS SOON AS POSSIBLE SO THERAPY WILL NOT BE DELAYED FOR YOUR PATIENT