



# 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**

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