Houston Therapy Consult

Providing Pediatric Therapy Services

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REFERRAL FORM

Patient Name:		
D.O.B.:	Sex:	
Parent Primary Language: ☐ English	☐ Spanish	☐ Other:
Insurance:	Insurance ID #:	
Address:		
City:	State:	Zip Code:
Parent/ Guardian:		
Home Phone:	Cell Phone:	

Medical /Social History: _____

_____

Services Ordered: ❒ **PT** ☐ **OT** ☐ **ST** ❒ **Nursing**

Diagnosis	**ICD10 Code:**
1.	1.
2.	2.
3.	3.
4.	4.

Referred by:

Physician's Name:

Phone: Fax:

MD PRESCRIPTION/CERTIFICATE OF MEDICAL NECESSITY FOR IN HOME THERAPY SERVICES

❒ PT ☐ OT ☐ **ST** ☐TO EVALUATE AND TREAT

Reason for Referral: _____

MD Signature: **Date:**

FOR OFFICE USE ONLY

Thank you for this referral of your patient. Unfortunately, we were unable to complete the evaluation requested above due to the following:

☐ Unable to contact the patient ☐ Patient never returned phone calls

☐ We scheduled evaluation but parent & patient not home

☐ Other: _____