Reliant Pediatric Therapy Services
"Helping children live functional and independent lives"

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THERAPY REFERRAL FORM

Patient Name _____ DOB_____

Address_____ Phone No._____

Parent _____ Alt. Phone No._____

Insurance Type _____ Insurance ID _____

Diagnosis Code: Description

_____ _____

_____ _____

PATIENT'S NEEDS/INITIAL ORDER FOR THERAPY

- ☐ **Physical therapy** to evaluate within 3 weeks of agency's receipt of MD signed referral orders. Treatment 1-4 visits per week may start within 3 weeks of payer prior authorization by agency.
- ☐ **Occupational therapy** to evaluate within 3 weeks of agency's receipt of MD signed referral orders. Treatment 1-4 visits per week may start within 3 weeks of payer prior authorization by agency.
- ☐ **Speech therapy** to evaluate within 3 weeks of agency's receipt of MD signed referral orders. Treatment 1-4 visits per week may start within 3 weeks of payer prior authorization by agency

PATIENT'S PRIMARY CARE PHYSICIAN INFORMATION

Physician Name _____

Address _____

Phone Number _____ Fax Number _____

Physician Signature_____Date_____