Reliant Pediatric Therapy Services

"Helping children live functional and independent lives"

PEDIATRIC THERAPY INTAKE / REFERRAL FORM

PATIENT INFORMATION

Date of Intake	Patient Name	Date of Birth

Services Requested	Parent/Guardian	Alternate Contact

Patient Address	Apt. No

City, State, Zip Code	Primary Language

Phone Number	Alternate Phone Number	School (if applicable)

Nursing Patient	Alternate Address for Patient to be Seen (ex. Daycare)

DIAGNOSIS

CODE	DIAGNOSIS

PCP INFORMATION

PCP NAME	PHONE NO.	FAX NO.

ADDRESS:	CITY, STATE, ZIP CODE

PRACTICE/CLINIC NAME	TAXONOMY CODE	LICENSE NO.	NPI NO.

INSURANCE INFORMATION

INSURANCE NAME:	INSURANCE ID NO.	SECONDARY INSURANCE

STAFFING NOTES

New Referrals		Feedback	
Able to Staff		Date Staffed	
Discipline Staffed		Add to Wait List	
Given to Therapist for Evaluation		Evaluating Therapist	
Assigned Therapist		Therapist notified	

REFERRAL SOURCE

REFERRAL SOURCE	REFERRAL CONTACT	PHONE NO.

PATIENT NOTES

ADDITIONAL PATIENT INFORMATION/NOTES