FIRST STEPS

Pediatric Therapy Specialists
Creating Solid Foundations for Learning...

Referral Form

Patient Information

Child's Name_____Date of Birth____/____/_____

Parent/Caregiver's Name_____

Primary Language Spoken in the Home ___English ___Spanish ___Other_____

Address_____

City_____State_____Zip_____

Home Phone(___)_____Cell Phone(___)_____

Medicaid #_____Medicaid HMO ___Yes___NO Type_____

Other Insurance___Yes____No If Yes, Name of Insurance_____

Physician Information

Person Referring _____

Physician Name_____

Physician Address_____

City_____State_____Zip_____

Phone_____Fax_____NPI#_____

Reason for Referral

Eval and Treat _____ST_____OT_____PT Date last seen by Physician_____

Diagnosis_____ Diagnosis Code_____

Physician's Signature_____Date_____

PLEASE SIGN DATE AND FAX BACK SO THAT WE MAY BEGIN THERAPY IMMEDIATELY

Phone: 972-871-1800 / Fax:972-871-1802

Toll Free Phone 888-725-6488 / Fax 888-725-6483