THERAPY SOLUTIONS OF GEORGIA, INC.

3615 BRASELTON HIGHWAY· SUITE 103· DACULA, GEORGIA 30019-5907

REFERRAL WORKSHEET

Appointment Scheduled: _____ Date: _____

PATIENT INFORMATION

Name: _____ (First) _____ (MI) _____ (Last) **Date of Birth:** ____ / ____ / ____

Parent/Guardian: _____ **Phone:** _____

Email: _____ Cell/Other Phone: _____

Address: _____ (City) (State) (Zip)

Physician's Name: _____ **Office Phone:** _____

Physician's Contact Person: _____ **Office FAX:** _____

Referral For: ☐ **Speech Therapy** ☐ **Occupational Therapy** **Comments/Remarks:** _____

_____

THERAPY INFORMATION

Diagnoses/Other Medical Conditions: _____

Has the child received therapy services before? ☐ **Yes** ☐ **No** **If yes, What?/Where?/When?** _____

_____

Does the child receive school services? ☐ **Yes** ☐ **No** **If yes, does he/she have an IEP?** ☐ **Yes** ☐ **No**

What is his/her educational placement? _____

Primary Speech Concerns: ☐ **Articulation** ☐ **Language** ☐ **Fluency** ☐ **Voice** ☐ **Feeding/Swallowing** ☐ **Other:** _____

_____

Primary OT Concerns: ☐ **Attention** ☐ **Writing** ☐ **Fine Motor** ☐ **Sensory Processing** ☐ **Other:** _____

_____

Are there any behavior concerns? ☐ **Yes** ☐ **No** _____

Other Services Received: ☐ **PT** ☐ **Other:** _____

INSURANCE INFORMATION

Insurance Company: _____ **Medicaid #** _____

Insured's Name: _____ (First) _____ (MI) _____ (Last) **Date of Birth:** ____ / ____ / ____

Insured's ID # _____ **Insured's Group #** _____

Insured's Employer: _____ **Phone:** _____

Plan Type ☐ **HMO** ☐ **PPO** ☐ **Other (specify):** _____

Please fax completed form to (678) 377-9609 and mail original prescription to 3615 Braselton Highway, Suite 103, Dacula, GA 30019-5907.