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.

Insurance Worksheet

Today's Date: _____/_____/_____ Representative's Name:_____

Effective Date: _____/_____/_____ Type of Plan ☐PPO ☐HMO ☐POS ☐_____

Plan Year: _____/_____ - _____/_____ ☐ No Pre-Existing

In Network:

Individual Deductible	$_____	met	$_____
Family Deductible	$_____	met	$_____
Ind. Out-of-Pocket Max	$_____	met	$_____
Fam. Out-of-Pocket Max	$_____	met	$_____
Copay	$_____	Coinsurance	_____%

Out-of-Network

Individual Deductible	$_____	met	$_____
Family Deductible	$_____	met	$_____
Ind. Out-of-Pocket Max	$_____	met	$_____
Fam. Out-of-Pocket Max	$_____	met	$_____
Copay	$_____	Coinsurance	_____%

Allowed $_____/Year _____Visits/Year _____ Used ☐ Combined with all therapies

Pre-Certification ☐Required ☐Not Required - for pre-cert call: _____

Procedures:				PCP Referral Required	Pre-cert Required
	92506 (Speech Evaluation)	☐Covered	☐Not Covered	☐	☐
	92507 (Speech Therapy)	☐Covered	☐Not Covered	☐	☐
	97003 (OT Evaluation)	☐Covered	☐Not Covered	☐	☐
	97530 (Therapeutic Activities)	☐Covered	☐Not Covered	☐	☐
	97533 (Sensory Integration)	☐Covered	☐Not Covered	☐	☐

Diagnoses:	Speech			OT			Limitations/Exclusions
	299.00	☐Covered	☐Not Covered	299.00	☐Covered	☐Not Covered	
	315.31	☐Covered	☐Not Covered	315.4	☐Covered	☐Not Covered	
	315.32	☐Covered	☐Not Covered	315.8	☐Covered	☐Not Covered	
	315.39	☐Covered	☐Not Covered	781.3	☐Covered	☐Not Covered	
	784.59	☐Covered	☐Not Covered	_____	☐Covered	☐Not Covered	
	_____	☐Covered	☐Not Covered	_____	☐Covered	☐Not Covered	
	_____	☐Covered	☐Not Covered	_____	☐Covered	☐Not Covered	

☐Unable to check diagnoses

☐ Sent Welcome Letter _____

☐ Requested Rx _____

Scheduling Attempts

___/___/_____ _____

___/___/_____ _____

___/___/_____ _____