



PHYSICIAN PRESCRIPTION/REFERRAL FORM

FAX 214.741.3655

214.467.9787 PHONE

Please use this form to send referral or prescription information to THERAPY 2000

PATIENT INFORMATION.....

Patient's Name _____ DOB ____/____/____

Parent/Caregiver Name _____

Address _____ Apartment _____

City _____ State _____ Zip _____

Home Phone_(_____) _____ Other Phone_(_____) _____

Medicaid # _____ Medicaid HMO? ___yes___no Type _____

Other Insurance? ___yes___no If yes, name of insurance company _____

Policy Holder Name _____ ID# _____

Insurance Policy Group # _____ Insurance Phone_(_____) _____

Diagnosis & ICD 9 Code _____ Onset Date ____/____/____

Diagnosis & ICD 9 Code _____ Onset Date ____/____/____

Diagnosis & ICD 9 Code _____ Onset Date ____/____/____

(Please send additional diagnoses or instructions on a second referral sheet if necessary)

Special Instructions/Precautions _____

PHYSICIAN INFORMATION.....

Physician Name _____ Clinic Name _____

Address _____ City, State Zip _____

Phone_(_____) _____ FAX_(_____) _____

RECOMMENDED THERAPY.....

PHYSICAL THERAPY

___ Evaluation Only
___ Evaluation and Treatment
___ Other _____

OCCUPATIONAL THERAPY

___ Evaluation Only
___ Evaluation and Treatment
___ Other _____

SPEECH-LANGUAGE PATHOLOGY

___ Evaluation Only
___ Evaluation and Treatment
___ Other _____

Physician Signature _____ Date ____/____/____

PLEASE SIGN AND DATE SO THAT WE CAN START CARE IMMEDIATELY

(Confidential Information)

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THERAPY 2000; 2535 Lone Star Dr Dallas, TX 75212