THERAPY WORKS
working wonders in children's lives

Therapy Referral/Prescription Form

Please fax this form to: **918-663-8754.**
TherapyWorks will call patient and schedule appointment.

Patient Information

Patient Name: _____ DOB: ___/___/_____

Parent/Guardian Name: _____

Address: _____ City/State/ZIP: _____

Home #: (____)_____-_____ Cell #: (___)_____-_____

Insurance Plan: _____ Insurance ID#: _____

Referral Information

Diagnosis: _____

Recommendation(s):

- ❑ Speech Therapy Evaluation & Treatment
- ❑ Speech Therapy Feeding Evaluation & Treatment
- ❑ Occupational Therapy Evaluation & Treatment
- ❑ Occupational Therapy Feeding Evaluation & Treatment
- ❑ Occupational Therapy Serial Casting (UE) Evaluation & Treatment
- ❑ Physical Therapy Evaluation & Treatment
- ❑ Physical Therapy Foot Orthotic Evaluation
- ❑ Physical Therapy Serial Casting (LE, Toe Walking) Evaluation and Treatment

Special Instructions/Precautions: _____

_____

Physician Information

Referring Physician: _____
Please Print

Phone #: (____)_____-_____ Fax #: (____)_____-_____

NPI #: _____ Medicaid Provider #: _____

I certify the above treatment is medically necessary for above patient/diagnosis.

X _____ ___/___/_____
Signature of Referring Physician Date

Please include clinical documentation with referral

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