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: ____________________

Cell 1 #: (_____)______-_________ Cell 2 #: (_____)______-_________

Referral Information

Diagnosis Code:____

Recommendation(s):

- ❑ Speech Therapy Evaluation & Treatment
  (Send doctor notes specifying problem)
- ❑ Occupational Therapy Evaluation & Treatment
- ❑ Physical Therapy Evaluation & Treatment
- ❑ ST/OT Feeding Evaluation & Treatment
  (Send doctor notes specifying problem)

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

7608 East 91st St. Tulsa, OK 74133
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info@therapyworkstulsa.com

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