PHYSICIAN REFERRAL FORM

Please fax to: 512-271-7839

DASH PEDIATRIC THERAPY | PHYSICAL OCCUPATIONAL AND SPEECH HOME HEALTH

Patient Information:

Patient Name: _____ **Patient DOB:** _____

Address: _____ **City/State/Zip:** _____

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

Primary Insurance: _____ **Insurance ID/Group:** _____

Secondary Insurance (if applicable: _____

Diagnosis and ICD 10 Code: _____ **Onset Date:** _____

Diagnosis and ICD 10 Code:_____ **Onset Date:** _____

Special Instructions/Precautions:_____

_Physician Information:

Physician Name: _____ **Practice Name:** _____

Address: _____ **Cit/State/Zip:**_____

Phone: _____ **Fax:** _____

If form is not completed by physician, please provide the information below:

Name: _____ **Organization** _____

Phone: _____ **How did you hear about us?** _____

Reccomended Therapy:

SPEECH THERAPY	OCCUPATIONAL THERAPY	PHYSICAL THERAPY
☐ EVAL & TREAT	☐ EVAL & TREAT	☐ EVAL & TREAT

☐ **Feeding therapy needed**

☐ **High Risk Infant** (<18m with history of prematurity/low birth weight, birth trauma or prolonged hospitalization AND medical dx)

Physician Signature: Date:

By signing this Prescription/referral Form, I am attesting that the Texas Health Steps checkup is current OR that a developmental screening has been performed within the last 60 days.

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PLEASE INCLUDE MOST RECENT WELL CHILD CHECK