Referral/Intake Form

Patient Information

Patient Name: ______________________________ **DOB:** ______________ **SEX:** F M
Address: ____ **City :** _____________ **State:** _________ **Zip:** ___________
Parent/Legal Guardian: ____
Home Phone: ___________________ **Work/Cell Phone:** _____________________
Emergency contact/number: ____
Language: English _____ **Spanish** _____ **Other** ______________________

Insurance

SS/Medicaid #: __________________
Insurance: ___________________________ **Policy #:** _________________________

Services

Principle DX: ______________________
Secondary DX: ___________________________

Functional limitations: Speech ___ **Paralysis** _____ **Hearing** ____ **Vision** _____ **Amputation** ____
Contracture ___ **Extremity involved (circle) RUE RLE LUE LLE**
Medications: ___________________________________
DME: DME/Supplies ordered ________ **None needed at this time:** ________
Allergies: _____________________________________
Parent Concerns: ____

Services requested:
Physical Therapy ___________ **ICD-10 Code:** ______________
Speech Therapy ___________ **ICD-10 Code:** ______________
Occupational Therapy ___________ **ICD-10 Code:** ______________

Referral

Referral source: _____________________________
Physician: _________________________ **Address:** ____
Phone: ______________________ **Fax:** ______________________________
Physician Signature: ____

1330 Shore District Dr. #2428, Austin, TX, 78741
Phone Number 512-770-6293 Fax 1-888-473-9584
info@soalhhs.com