Strides of Strength Therapeutic Services, INC.
2717 Gaston Farm Rd
Chester, SC 29706
(O) 803-374-6255
(F) 803-219-3947

REFERRAL/INTAKE INFORMATION

Date of Referral:_____ Location of Service:_____Home _____Clinic
Referring Agency/Case Coordinator/Phone#/Email

_____

Referral for: _____PT_____OT_____ST
Child's Name:_____
DOB:_____ M_____ F_____
Address:_____
Parent/Guardian Names:_____
Phone Numbers:_____
Email Address:_____
Emergency Contact:_____ Phone:_____
Reason for Referral: _____
Evaluate and treat as indicated.
PLEASE SELECT BY CIRCLING: This patient **IS** or **IS NOT** cleared for Hippotherapy.
Diagnosis: 1)_____ (ICD10 code)_____
Diagnosis: 2)_____ (ICD10 code)_____
Medical History:_____

_____

Family History:_____

_____

Additional Comments:_____

_____

Payer Source: Medicaid #:_____ MCO:_____
Insurance Information:
Carrier Name:_____ Plan:_____
Policy Number:_____ Group Number:_____
Contact Number:_____
Referring Clinician Information:
Doctor's Name:_____ Phone:_____
Fax:_____ Email:_____

Please complete this referral form and attach a signed MD order for OT evaluate and treat as indicated. Also, include on the order that patient IS or IS NOT cleared for Hippotherapy.

STRIDES OF STRENGTH
THERAPEUTIC SERVICES