The Occupational
Therapy Clinic, LLC

Phone: 346-588-1495 Fax: 346-584-3080

PHYSICIAN'S PRESCRIPTION / REFERRAL FORM

Patient name:_____ DOB:_____ Phone: _____

Parent/Caregiver Name:_____

Address: _____

Medicaid #: _____ Medicaid HMO? Yes_ No_ Plan Name:_____

Other Insurance? Yes_ No_ If yes, name of insurance Company:_____

Policy Holder Name: _____ ID# _____

Insurance Policy Group # _____ Insurance Phone: _____

Diagnosis:_____ICD-10: _____

Diagnosis:_____ ICD-10:_____

History/Precautions: _____

Physician's Name/Title:_____

Phone:_____ Fax:_____

Address:_____

Email:_____ NPI #: _____

Physician's Recommendation	
⚪	OCCUPATIONAL THERAPY EVALUATION AND TREATMENT (treatment included)
⚪	OCCUPATIONAL THERAPY EVALUATION AND REPORT (no treatment included)

_____

PHYSICIAN'S 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.