Professional Therapy Services, Inc.
1015 Oakhurst Drive
Charleston, WV 25314
Office: 304-345-8101 Fax: 304-345-7386

Patient Referral Form

Referral Date: _____

Name: _____ DOB: _____

Address: _____

_____

Guardian/Caregiver: _____

Home: _____ Cell: _____ Work: _____

Best number to contact for scheduling: Home Cell Work

Referred By: Dr. Office Parent Birth-to-Three Waiver Agency

Therapy Needed: Music Speech Physical Occupational

Available for Morning Assessment? Yes No

Diagnosis/Presenting Problem(s):

_____

_____

The following information is required for ALL referrals:

	Included
Doctor's order for therapy	
Front and back of insurance card	
* Waiver budget (if waiver client)	

Insurance Company: _____ ID#: _____
Benefits Phone Number: _____
Policy Holder: _____ Policy Holder DOB: _____
Policy Holder SS#: _____

Referring Physician: _____ Contact: _____

Phone: _____ Fax: _____

Note that if a child is under three years old, many insurance companies will not cover therapy. These children are eligible for WV Birth-to-Three program, (304) 414-4460 *