ADVANCED
THERAPY SOLUTIONS

120 N Perkins Road Suite F Stillwater, OK 74075 ❖405.564.2701❖www.ats-stillwater.com

Order Form

Service: ☐ **Speech-Language Pathology**
☐ **Occupational Therapy**
☐ **Lymphedema Therapy**

Referring Provider: _____

Referring Provider Fax #: (_____) _____ - _____

Referring Provider Phone #: (_____) _____ -_____

Patient Name: _____

Patient DOB: _____ /_____ /_____

Patient Phone Number: (_____) _____ - _____

Primary Insurance: _____ Policy#: _____

Secondary Insurance: _____ Policy #: _____

Primary diagnosis (ICD-10): _____

All pertinent medical diagnoses (ICD-10): _____

Please include copies of insurance card, patient face-sheet, last office visit note, and any other pertinent records or test results.

Comments/Reason for Referral:

_____

_____

_____

_____

By signing below, I order and authorize the therapists at Advanced Therapy Solutions, LLC to evaluate and treat the above patient as indicated.

Provider (printed):_____

Provider (signature):_____ Date: _____

Please submit this form and related information via fax to 888-581-6850 or via email to therapy@ats-stillwater.com

This form is available on our website: http://www.ats-stillwater.com/new-patients.html