Park West Corporate Center E Suites, 555 Round Rock West Drive,
Building E Suite E 223, Round Rock TX 78681
(254) 290-3333 office (254) 300-9246 fax

Client Referral Form

Patient Name: _____ **DOB:**_____

Patient Phone:_____ **Email:**__ _____

Cell Phone:_____ **Alt Contact:** _____

Address:_____

Case ID Number (if applicable):_____

Funding Source (Check Boxes that apply):

☐ **Self Pay** **FSM DOES NOT FILE HEALTH INSURANCE** (Medicare, Medicaid, Private)

☐ **Worker's Comp** **FSM REQUIRES PRE-PAYMENT**

Case Manager: _____ Phone: _____

Email: _____ Fax: _____

Company Name: _____

☐ **Texas Workforce Commission:** **An invoice for service will be sent to the TWC counselor**

Counselor Name: _____

Phone: _____Email: _____

Field Office: _____

Reason for Referral:

☐ **Occupational Therapy Driving Evaluation & Training**

☐ New Driver ☐ Licensed Driver

☐ **Adaptive Equipment Assessment & Order**

☐ **Other:** _____

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Items Required:

The following items are required from third party referral sources (Worker's Comp & TWC)

- Physician's Order: Occupational Therapy to evaluate for Fitness to Drive
- Copy of active Driver's License or Permit
- Pertinent Medical Records
- An intake interview with the client will be completed once all paperwork has been received

Submission of Referral Form:

Referral forms can be submitted via the following methods:

Faxed to: (254) 300-9246

Emailed to: Megan@homeanddriving.com

Acknowledgment of Referral:

Functional Stability & Mobility (FSM) will contact the client to notify them that a consult has been received. If the *client is self-pay*, we will set appointment & once services are rendered the results will be faxed to the referring physician upon client consent. If the *client is funded by a third party,* FSM will also contact the designated person to determine the parameters of the invoice for payment.