REFERRAL FORM

Please print, fill out and fax. **All information is required for authorization from the insurance carrier.**

PATIENT INFORMATION

NAME: ___________________________________ DOB: _______________ SSN#: ___________________________

PHONE: 1._________________________ 2.__________________________3._________________________________

PLAN: **( )** Medicaid **( )** Commercial **( )** Medicare **( )** Other: ______________________

PLAN ID#: ____

DIAGNOSIS: 1.__________________________2.__________________________3.____________________________

ICD-10: 1.________ 2._________ 3._________ Area(s) of concern: ______________________________________

3yrs and younger **= ( ) Patient was referred to ECI. Patient elected alternative place of service. INITIALED: ________**

REQUESTED SERVICES

( ) OCCUPATIONAL THERAPY

( ) Evaluate and Treat **( )** Re-Evaluate and Continue Treatment **( )** Plan of Care / Frequency: ___________________

( ) PHYSICAL THERAPY

( ) Evaluate and Treat **( )** Re-Evaluate and Continue Treatment **( )** Plan of Care / Frequency: ___________________

( ) SPEECH THERAPY

( ) Evaluate and Treat (**)** Re-Evaluate and Continue Treatment **( )** Plan of Care / Frequency: ___________________

( ) DURABLE MEDICAL EQUIPMENT

ITEM: ________________________________ DESCRIPTION: ____________________________ ( ) Title XIX Form Included

REQUESTING PHYSICIAN

Physician's Name: ___________________________ Physician's Signature: __________________________________

NPI #: _____________________________________ FAX #: ____

Email: ____________________________________ Phone: ____

Completed By: ____ Date: _____________________________

TEXAS REHAB SPECIALISTS

New Braunfels Clinic ***or*** ***Castroville Clinic***

Fax:830-632-5884 Fax: 830-469-1077

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