PRIME PEDIATRIC THERAPY
Little Minds, Limitless Potential

PHYSICIAN / PROVIDER REFERRAL FORM

Speech Therapy | Occupational Therapy | Physical Therapy
www.myprimepediatric.com | info@myprimepediatric.com

PATIENT INFORMATION

Patient Name: _____	**Date of Birth:** _____
Parent / Guardian: _____	**Phone:** _____
Address: _____	**City / ZIP:** _____
Insurance: _____	**Member ID:** _____

REFERRAL / THERAPY REQUEST

Please evaluate and treat as medically necessary:

☐ Speech-Language Therapy ☐ Occupational Therapy ☐ Physical Therapy

Diagnosis / ICD-10 Code(s): _____

Reason for Referral / Clinical Concerns:
_____
_____

CLINICAL INFORMATION

Relevant Medical History / Precautions: _____ _____	**Allergies:** _____ **Medications:** _____
Recent Hospitalizations / Surgeries: _____	**Assistive Devices / Equipment:** _____

REFERRING PROVIDER INFORMATION

Provider Name: _____	**NPI:** _____
Practice / Facility: _____	**Phone:** _____
Fax: _____	**Email:** _____
Provider Signature: _____	**Date:** _____

Instructions: Please return the completed referral with relevant clinical documentation and insurance information to Prime Pediatric Therapy. Our team will coordinate next steps with the family and referring provider.

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