Associates in Pediatric Therapy™

Advancing Patients to Their Next Therapeutic Level

NEW PATIENT REFERRAL FORM

Locations across IN, KY, TN

Fax #: 502-805-1511 • General Office Line #: 502-633-1007

Rx must include:

1. "Evaluate and Treat" for specified therapy
2. Date, written diagnosis, ICD-10 code, and D.O.B. of patient signature by Medicaid credentialled provider for patients with Medicaid

Rx must be included with the attached referral form to avoid delay in services

Referral information must include: Parent/Guardian names and contact information.

PATIENT NAME: _____DOB: _____/_____/_____

GENDER: _____SS#:_____

PARENT/GUARDIAN: _____PHONE #: _____

ADDRESS: _____

CITY:_____STATE:_____ ZIP:_____

PRIMARY INSURANCE: _____MEMBER ID:_____

GROUP #: _____ SUBSCRIBER NAME:_____ DOB:____/_____/_____

NAME OF REFERRING DOCTOR:_____PHONE #_____

SPECIALITY:_____REFERRING OFFICE CONTACT: _____

THERAPY REFERRAL FOR THE FOLLOWING THERAPY (PLEASE CIRCLE ALL THAT APPLY):

Speech Therapy	Occupational Therapy	Physical Therapy	Audiology (Shelbyville location only)	ABA Therapy

DOES PATIENT REQUIRE SERVICES TO BE DONE IN THE HOME? YES / NO