THERAPYWORKS

changing lives for 25 years

Therapy Referral/Prescription Form

Please fax this form to: **918-663-8754.**

TherapyWorks will call patient and schedule appointment.

Patient Information

Name: _____ DOB: ___/___/_____

Address: _____ City/State/ZIP: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____

Cell #: (_____)_____-_____ E-mail: _____

Insurance Plan: _____ Insurance ID#: _____

Referral Information

Diagnosis: _____

Recommendation(s):

- ❑ Physical Therapy Evaluation & Treatment
- ❑ Occupational Therapy Evaluation & Treatment
- ❑ Speech and Language Evaluation & Treatment
- ❑ Orthotics/Splinting/Casting Evaluation
- ❑ Other _____

Special Instructions/Precautions: _____

_____

_____

Physician Information

Referring Physician: _____
Please Print

Phone #: (_____)_____-_____ Fax #: (_____)_____-_____

NPI #: _____ Medicaid Provider #: _____

Physician E-mail: _____

I certify the above treatment is medically necessary for above patient/diagnosis.

X _____ ___/___/_____
Signature of Referring Physician Date

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