



# FIRST STEPS

NURSING AND THERAPY

## PATIENT REFERRAL FORM

FAX 210.945.0002 | PH 210.945.0000 | WWW.FSNTS.COM

Please use this form to send referral information to FIRST STEPS NURSING AND THERAPY

TREATMENT DISCIPLINES:  Speech Therapy  Occupational Therapy  Physical Therapy  Private Duty Nursing

EVALUATE AND TREAT (frequency to be determined upon Evaluation) up to 180 days from start of authorization period approved by Primary Insurance and/or Medicaid

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_ / \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Caregiver Full Name: \_\_\_\_\_

Home Phone:(\_\_\_\_) \_\_\_\_\_ Work Phone:(\_\_\_\_) \_\_\_\_\_ Alternate:(\_\_\_\_) \_\_\_\_\_

ICD-10/Diagnosis:  Other \_\_\_\_\_

- F84.0 Autism
- F90.9 ADHD
- F80.89 Dev. Speech Disorder
- F80.1 Dev. Speech and Language Disorder
- 169.990 Apraxia of Speech
- G80.9 Cerebral Palsy (Infantile)
- R62.51 Failure to Thrive
- F80.2 Mixed Expression/Receptive Language Disorder
- R26.9 Abnormality of Gait
- Z931 Gastronomy Status
- Z930 Tracheotomy Status
- F84.9 Pervasive Developmental Delay (PDD)
- M43.6 Torticollis
- R48.2 Apraxia (non-speech)
- R62.50 Developmental Delay
- R13.10 Dysphagia

### INSURANCE INFORMATION

Primary Carrier Name: \_\_\_\_\_ Member ID#: \_\_\_\_\_ Group/Policy#: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medicaid ID #: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

### PRACTICE INFORMATION

Practice Name: \_\_\_\_\_ Physician: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ / \_\_\_\_\_ Zip: \_\_\_\_\_

Fax Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Referred By: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Please affirm THSteps is current for this patient and provide most recent checkup/THSteps/Developmental Screening.

THSteps checkup current and provide date patient was last seen by MD \_\_\_\_/\_\_\_\_/\_\_\_\_.

I certify that this patient is under my care. The rehabilitation services prescribed by me are medically necessary and in accordance with a care plan established and periodically reviewed by me.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(Confidential Information)

Unless otherwise indicated or obvious by the nature of this transmittal, the information contained in this FAX message is privileged and confidential, intended for the use of the designated recipient (or the employee or agent responsible to deliver to the designate recipient). You are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately via phone call to 210-945-0000.

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www.FirstStepsNursingandTherapy.com