FIRST STEPS
NURSING AND THERAPY

PATIENT REFERRAL FORM

FAX 210.945.0002 I PH 210.945.0000 I 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)