Helping Hands Therapy Referring Physician Information

Today's Date:	EPDST Screening Date:

Patient Information

Child's Name:	DOB:
Social Security Number:	Medicaid Number:
Parent/Legal Guardian:	Phone Number:
Address:	

Primary Physician Information

Name:	Address:
Provider Number:	
Telephone:	
Fax:	
Signature:	

Therapy Referral Information

Discipline:	( ) Occupational Therapy	( ) Physical Therapy	( ) Speech Therapy
Valid for:	( ) Evaluate & Treatment	( ) Evaluate Only	( ) Other _____
Length:	( ) 1 year	( ) ___ months	( ) Other _____
Reason:	( ) Dev. Delays	( ) Sensory	( ) Other _____
Comments:			

Consultant's Name: _____ Phone: _____