Patient Referral Form

Please fax completed form to
(803) 753-9415

Patient Name: _____ Date: _____

Sex: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip:_____

Guardian: _____

Phone: _____ Cell: _____

Email:_____

Referring Physician: _____

Phone: _____ Fax: _____

Private Insurance: _____

Group #:_____ Member #_____

Phone: _____ Fax: _____

Medicaid/Managed Care Name: _____Medicaid #:_____

Is the patient currently being treated by an occupational or physical therapist? YES ☐ NO ☐

If yes, please indicate where and how often _____