REFERRAL INTAKE FORM

Sugar Land, Texas
Phone: 281-393-9009
Fax: 281-393-9009

NEW PATIENT INTAKE FORM				Intake Date:	
SERVICES REQUESTED	☐ Occupational Therapy		Physical Therapy		Speech Therapy
	☐ Aquatic Therapy		ABA		Lokomat/ Robotic Therapy
PERSONA INFORMATION					
Patient Name:		Date of Birth:		Gender:	Male Female
Street Address:		City:		State: TX	Zip code:
Guardian Name:		Relationship to Patient:			
Phone Number:		Secondary Phone Number:			
Can we text you:	Yes No	Gate Code if applicable:		N/A	
Primary Language:	☐ English ☐ Spanish ☐ Other:				
Patient Availabilty:	All Day Morning Afternoon After School Other:				
Place of Treatment:	☐ Home ☐ Katy Clinic	Phone Number:			
Address of Treatment if other than home:					
DIAGNOSIS					
Code		Diagnosis Description			
INSURANCE INFORMATION					
Primary Insurance:		Secondary Insurance:			
Insurance ID Number:		Insurance ID Number:			
Group Number:		Group Number:			
Policy Holder Name:		Policy Holder Name:			
Policy Holder DOB:		Policy Holder DOB:			
Provider Phone Number:		Provider Phone Number:			
REFERRAL/PHYSICAN INFORMATION					
PCP Name:		Address:			
Phone Number:		City:		State: Tx	Zip Code:
Fax Number:		License Number:		Taxonomy Numer:	
Practice/Clinic Name:		NPI Number:			
Last well child check up:		Last Hearing screening:			
REFERRAL SOURCE					
Referral Source:		Referral Contact:			
COORDINATION OF CARE					
Other Medical Services:	Nursing OT ☐ PT ST				
Other:		Date of Discharge:			
Name of agency:		Phone Number:			
STAFFING NOTES					
Able to Staff:		Treating Therapist:			
Discipline staffed:		Evaluation Therapist:			
PATIENTS NOTES					
Additional Comments:					
Intake Information was taken by :					