Impact Therapy Solutions
Pediatric and Adult Therapy
(254)892-0527

GRACE THERAPY
More than just words

PHYSICIAN PRESCRIPTION AND REFERRAL FORM

REQUESTING FOR THERAPIST TO EVALUATE AND TREAT IF RECOMMENDED
_____SPEECH & LANGUAGE / FEEDING THERAPY
_____ PHYSICAL THERAPY _____ OCCUPATIONAL THERAPY

PATIENT NAME:_____ DOB: ____/____/_____
CHILD SPEAKS: ____ENGLISH _____SPANISH ____OTHER_____
PARENT/CAREGIVER NAME: _____
PRIMARY LANGUAGE ____ENGLISH____SPANISH____OTHER_____
ADDRESS: _____ APT #_____
APT NAME: _____CITY_____ ZIP_____
MAIN PHONE: _____ ALT PHONE_____
*HAS CHILD RECEIVED THERAPY SERVICES PRIOR TO THIS REFERRAL? ___YES___NO
WHEN? _____WHERE? _____

Insurance Information

MEDICAID #_____ TYPE_____
OTHER INSURANCE___YES ___NO INSURANCE NAME: _____
POLICY ID #_____ POLICY GROUP #_____

PHYSICIAN NAME: _____
NPI # _____ ADDRESS: _____
CITY _____ ZIP_____
PHONE # _____ FAX # _____

(PRIMARY CARE PHYSICIAN WILL BE NOTIFIED OF EVALUATION RESULTS BEFORE THERAPY IS INITIATED)

_____
PHYSICIAN SIGNATURE DATE

Conveniently located at:
201 Paloma Dr
Temple, TX 76502

Phone: (254) 892-0527
Fax: (254) 853-4959

To avoid delays in therapy, please sign and return as soon as possible. Thank you!

DIAGNOSIS (CHECK ALL KNOWN):
__ CP __MR __MD
__SEIZURES
__G-TUBE/BUTTON
__DYSPHAGIA
__TRACH
__DIABETES
__DEVELOPMENTAL DELAY
__INVITRO DRUG EXPOSURE
__RECEPTIVE LANG DEFICITS
__EXPRESSIVE LANG DELAY
__ARTICULATION DELAYS
__NEUROLOGICAL DEFICITS
__RESPIRATORY DISTRESS
__CONGENTIAL HEART DEFECTS
__HYDROCEPHALUS
__DOWN SYNDROME
__PREMATURE BIRTH
__GASTROINTESTINAL PROBLEMS
__GENETIC DISORDER
__VISUALLY IMPAIRED
__HEARING IMPAIRED
__ASTHMA
__SPINA BIFIDA
__FOOD ALLERGIES
__STUTTERING
__AUTISM
__HIV POSITIVE
__ADD/ADHD
__FRAGILE X
__TORTICOLLIS
__TOE WALKING
__CONTRACTURES
__QUADRAPLEGIA
__HEMIPLEGIA
__PARAPLEGIA
__DIPLEGIA
__MONOPLEGIA
__OTHER_____
_____
_____
_____
_____

LIMITATIONS:_____
_____
_____
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