compleatKiDZ

REFERRALS ONLY

Fax: 888 244-5493
www.compleatkidz.com

Patient Name: _____ DOB: _____

Diagnosis: _____

Address: _____

Parent/Guardian Name: _____

Phone: _____ Email: _____

Evaluate and Treat for the selected Therapies/Services (check all that apply):

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy

Required attachments:

- ☐ Patient's demographic sheet
- ☐ Physician notes pertaining to diagnosis.

☐ ABA (RB-BHT)

☐ Evaluating therapist may add any of the above therapies/services to these orders if their assesment indicates a need to include them to fully address the patient's needs.

Specific Requests: ☐ Interpreter _____ (Language) ☐ Orthotics ☐ Swallowing

Special Instructions: _____

Carolina Access Medicaid # (Must be Completed) _____

PCP NPI # _____ Group NPI # _____

Insurance _____ ID # _____

Group # _____ Phone # _____

Requesting Clinic

Name _____ Address _____

_____ _____
(Physician - Printed) (Person Requesting Services/Appointment)

_____ _____
(MD or DO signature - Required for autism screen) (Date)