

PHYSICIAN PRESCRIPTION AND REFERRAL FORM

REQUESTING FOR THERAPIST TO EVALUATE AND TREAT IF RECOMMENDED					
SPEECH & LANGUAGE / FEEDING THERAPY					
PHYSICAL THERAPY OCCUPATIONAL THERAPY					
DAYTIME	AFTER SCHOOL				
PATIENT NAME:				DOB:	/ /
CHILD SPEAKS:					
PARENT/CAREGIV					
PRIMARY LANGUA					
ADDRESS:	 _				
APT NAME:			CITY	ZIP_	
MAIN PHONE:					
*HAS CHILD RECEI	VED THERAPY SEF	RVICES PRIOR T	O THIS REFERRA	L?YES	_NO
WHEN?		WHE	RE?		
<u>Health Plan and Superior HealthPlan.</u> We also partner with commercial payers on an out- of-network basis and when Medicaid is secondary. We are adding new payers monthly, so please contact our office for the most up-to-date information.					
MEDICAID #			TYPE		
OTHER INSURANC					
POLICY ID #		POLIC	Y GROUP #		
PHYSICIAN NAME:					
	ADDRESS:				
CITY			ZIP		
PHONE #		FAX #			
(PRIMARY CARE P	HYSICIAN WILL BE NO	OTIFIED OF EVALU	ATION RESULTS <u>BE</u>	FORE THERAPY	' IS INITIATED)
PHYSICIAN SIGNAT	TURF		D	ATF	

6301 GASTON AVE, STE 750 DALLAS, TX 75214 OFFICE: 214-295-5374 FAX: 214-245-5217

LIMITATIONS:

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

__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

__GASTROINTESTINAL PROBLEMS

TO AVOID DELAYS IN THERAPY, PLEASE SIGN AND FAX TO SAGE CARE THERAPY SERVICES

AS SOON AS POSSIBLE, THANK YOU!

WWW.SAGECARETHERAPY.COM

SAGE CARE THERAPY REFERRAL PROCESS

- 1. THERAPY NEED IS IDENTIFIED BY PARENT OR PHYSICIAN.
- PHYSICIAN'S OFFICE WILL THEN FAX REFERRAL FORM TO SAGE CARE THERAPY OFFICE.
- 3. OFFICE STAFF WILL CONTACT REFERRAL SOURCE TO CONFIRM RECEIPT OF REFERRAL WITHIN 24 HOURS.
- 4. SAGE CARE THERAPY OFFICE WILL CONTACT FAMILY TO INITIATE INTAKE PROCESS WITHIN 24 HOURS OF RECEIVING REFERRAL.

NOTE: SAGE CARE THERAPY'S OFFICE MAY REQUEST ADDITIONAL MEDICAL DOCUMENTATION FROM PHYSICIAN'S OFFICE.

- 5. AFTER APPROVAL FOR EVALUATION IS RECEIVED, THERAPIST WILL EVALUATE CHILD AND COMPLETE A REPORT WITH RECOMMENDATIONS FOR THERAPY SERVICES.
- 6. PLAN OF CARE AND CCP REQUEST FORM WILL THEN BE SENT TO PHYSICIANS OFFICE FOR PHYSICIAN TO SIGN AND DATE.
- 7. PHYSICIAN'S OFFICE WILL RETURN SIGNED PLAN OF CARE AND CCP REQUEST FORM TO SAGE CARE THERAPY OFFICE AS SOON AS POSSIBLE.
- SAGE CARE THERAPY OFFICE WILL SEND EVALUATION/PLAN OF CARE TO MEDICAID / INSURANCE OFFICE FOR AUTHORIZATION APPROVAL.
- 9. MEDICAID / INSURANCE OFFICE WILL GIVE AUTHORIZATION APPROVAL AND RETURN IT TO SAGE CARE THERAPY OFFICE.

NOTE: TREATMENT MAY BEGIN ONCE SIGNATURE ON PLAN OF CARE IS RECEIVED AND WHEN AUTHORIZATION IS RECEIVED FROM PAYER SOURCE

IF YOU HAVE ANY QUESTIONS PLEASE FEEL FREE TO CONTACT OUR OFFICE

SAGE CARE THERAPY SERVICES

PEDIATRIC HOME HEALTH THERAPY PROVIDER

6301 GASTON AVE, SUITE 750 - DALLAS, TX 75214

OFFICE: 214-295-5374 FAX: 214-245-5217

www.sagecaretherapy.com