



# Dumas Therapy

3203 B Vineville Avenue. Macon, Georgia 31204  
Office: (478) 737-9759 Fax (478) 475-1010

## Therapy Referral Form

Patient's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Parent's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ email: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relation to the child: \_\_\_\_\_

Referred for the Occupational Therapy program below:

\_\_\_\_\_ Early Therapy Interventions Program (birth to 3)  
\_\_\_\_\_ Autism Program  
\_\_\_\_\_ Neuromuscular/Massage Program  
\_\_\_\_\_ Visual Impairments Program  
\_\_\_\_\_ Neurodevelopmental Program  
\_\_\_\_\_ Sensory Integration Therapy

Referring Physician: \_\_\_\_\_  
Facility Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_ email: \_\_\_\_\_

Please fax a copy of the prescription with referral form.

[www.dumasterapy.com](http://www.dumasterapy.com)

*Specialty center for Autism, Developmental Delay, Cerebral Palsy and Visual Impairments*