3040 Riverside Drive, Suite B-1 Macon, Georgia 31210 (478) 731-9477

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 to (478)475-1010