Interact Pediatric Therapy Services, PLLC

5603B W Friendly Ave. Ste #274 Greensboro, NC 27410
www.interactpeds.com

Referral/Intake form

Name: ____DOB: ______________________________

Parent/Guardian Names:____

Address: _________________________________ City_______________________Zip_________________

Phone Number: _________________Work Number: ________________Cell Phone Number: _____________

E-mail:____________________________________ Please circle preferred method of communication

Diagnosis (if known): ____

Primary Physician (Phone and Address): ____
____

Referring Provider (if different):____

Service(s) requested: Speech Therapy_______ Occupational Therapy______ Physical Therapy_____

How did you hear about Interact Pediatric Therapy Services? __________________________________

Where would you prefer your child be seen: Clinc ________ Home___________ Daycare_____________

If daycare, what is name of daycare and where is it located____
____

Insurance Information:

Primary Insurance:__________________________ Name of Insured:________________________________

Insured SS #:____________________ Member ID:__________________________ Group #______________

Insured Date of Birth_______________ Customer Service #:_____________________________________

Claims Address (found on back of card):____

Secondary Insurance:______________________ Name of Insured:_________________________________

Member ID:_______________________________ Group #:____

Claims Address (found on back of card):____

Cust Service #:__________

Medicaid Number:_____________________________

Effective Date:_________________

Interact Pediatric Therapy Services, PLLC

5603B W Friendly Ave. Ste #274 Greensboro, NC 27410
www.interactpeds.com

REQUEST FOR PHYSICIANS ORDERS

CONFIDENTIAL INFORMATION ATTACHED

Patient Name:__________________________ **DOB:**______________

Diagnosis: 315.32 (Speech) _____; 783.3 (Feeding Disorder) _____; 781.3 (Lack of Coordination)_______; Other____________

Speech Therapy Evaluate and Treat ____________

_____1x weekly for 6 mos; _____ 2x weekly for 6 mos; ____2x monthly for 6 mos

Occupational Therapy Evaluate and Treat_______

____1x weekly for 6 mos; _____ 2x weekly for 6 mos; ____2x monthly for 6 mos

_______ Splinting for R UE/ L UE/ B UE

Physical Therapy Evaluate and Treat_________

_____1x weekly for 6 mos; _____ 2x weekly for 6 mos; ____2x monthly for 6 mos

_______ Splinting/orthotics for R LE/ L LE/ B LE

___________________________________ ________________________

Physican Signature Date

___________________________________ _________________________

Physician's Name Printed office NPI