THERAPY SPECIALISTS *of Georgia*

"Covering Everything Under the Umbrella"
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Kay W. Hancock, Owner

PRESCRIPTION/LETTER OF MEDICAL NECESSITY

☐ Occupational Therapy ☐ Physical Therapy ☐ SpeechTherapy ☐ Feeding Therapy
(Check Boxes that Apply)

Referred by: (MD Name)_____ Tele# _____

Fax#:_____

PATIENT INFORMATION - *REQUIRED*

Patient Name: _____ Address: _____

DOB: _____ _____

Patient Telephone Numbers: **Insurance Information:**

Home: _____ Primary: _____

Work: _____ Secondary: _____

Cellular: _____ Parent Name: _____

Patient HX Information Relevant to Treatment DX or Send copy of H&P:

_____

_____

Primary concern/Reason for Referral:

_____

Physician Signature: _____ **Date:** _____

DIRECTIONS/NOTES FOR PHYSICIAN
**PLEASE FAX WITH THIS REFERRAL
1.This completed form
2.Copyof front/back of Insurance Card
3.Any HX/PHYSICAL

***EXAMINATION MAY INCLUDE ALL OR SOME OF THE FOLLOWING
-Speech/Language/Fluency Evaluation
- Dysphagia/Feeding/Oral Motor Evaluations
-Voice Evaluation
-Physical Evaluations for Motor Development
-Fine Motor and Sensory Evaluation
-Activities of daily living through adaptive equipment,cues,sensory. et. al,

**RECOMMENDATIONS MAY INCLUDE:
-continue with current plan/goals
-initiation of treatment plan/goals
-Monitor PT/Discharge Pt