



## REFERRAL

Date: \_\_\_\_\_

Name of Child: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent(s) Name: \_\_\_\_\_

Address: \_\_\_\_\_ Patient's Phone #: \_\_\_\_\_

\_\_\_\_\_

-----  
Insurance: \_\_\_\_\_ Policy/Member ID #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Group #: \_\_\_\_\_

-----

Doctor's Office: \_\_\_\_\_

### Please Circle Services Requested:

Physical Therapy

Occupational Therapy

Speech Language Therapy

### Nature of Problem and Areas to Assess/Treat:

\_\_\_\_\_

**PLEASE SUBMIT COMPLETED REFERRAL FORM THROUGH ONE OF THE FOLLOWING WAYS:**

Email to [info@pediatricdt.com](mailto:info@pediatricdt.com)

Fax to (910) 483-8335

OR

Turn in to Amy Sparks, Principal of The School of Hope

August 15, 2019

Hello Parents,

We here at Pediatric Developmental Therapy (PDT) are excited about the start of a new school year, and our therapists are looking forward to working with the students at The School of Hope.

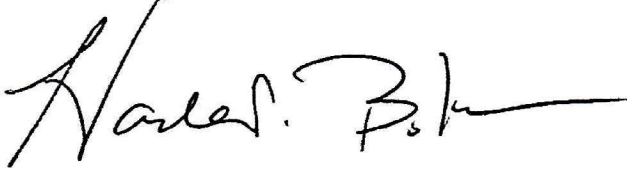
PDT provides speech, occupational, and physical therapy at The School of Hope for children who qualify and whose parents desire it for them.

Attached is a referral form for our services. If you are interested, please complete the form and submit it through one of the following ways:

- Email the completed form to [info@pediatricdt.com](mailto:info@pediatricdt.com)
- Fax the completed form to (910) 483-8335
- Or, turn in the completed form to Amy Sparks, Principal of The School of Hope

Thank you for allowing us the opportunity to be a part of helping your child reach his/her full potential.

Sincerely,

A handwritten signature in black ink, appearing to read "Haden Boliek". The signature is fluid and cursive, with a long horizontal stroke at the end.

Haden Boliek

President/Owner

Pediatric Developmental Therapy

(910) 483-8331

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