The Speech Path
Your PATH to success starts here.

Occupational Therapy
Physical Therapy
Speech Therapy

Prescription & Letter of Medical Necessity

Referred By: _____ (Your MD Name) Phone: _____

Fax: _____

Patient Information: (Required)

Name: _____ DOB: _____

Address: _____

_____

Patient Phone Numbers:

Home: _____

Cell: _____

Work: _____

Insurance Information:

Primary: _____

Secondary: _____

Parent: _____

Patient Diagnosis or Reason for Referral:

_____

_____

Select the Discipline(s):

☐ Speech Therapy Evaluation & Treatment

☐ Occupational Therapy Evaluation & Treatment

☐ Physical Therapy Evaluation & Treatment

☐ Speech Therapy-Feeding Evaluation & Treatment

☐ Occupational Therapy-Feeding Evaluation & Treatment

Physician Signature: _____ Date: _____

If you are referring a new patient, please include a copy of the patient's demographics sheet and a recent office visit note.

Thank you for thinking of The Speech Path with this referral!

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