



ADVANCED
THERAPY SOLUTIONS

120 N Perkins Road Suite F Stillwater, OK 74075 ❖ 405.564.2701 ❖ www.ats-stillwater.com

Order Form

Service: **Speech-Language Pathology**

(Speech, Language, Feeding, Swallowing, Voice, Cognition)

Lymphedema

Referring Provider: _____

Referring Provider Fax #: (_____) _____ - _____

Referring Provider Phone #: (_____) _____ - _____

Patient Name: _____

Patient DOB: ____ / ____ / _____

Patient Phone Number: (_____) _____ - _____

Primary Insurance: _____ Policy#: _____

Secondary Insurance: _____ Policy #: _____

Primary diagnosis (ICD-10): _____

All pertinent medical diagnoses (ICD-10): _____

Please include copies of insurance card, patient face-sheet, last office visit note, and any other pertinent records or test results.

Comments/Reason for Referral:

By signing below, I order and authorize the therapists at Advanced Therapy Solutions, LLC to evaluate and treat the above patient as indicated.

Provider (printed): _____

Provider (signature): _____ Date: _____

**Please submit this form and related information via fax to 888-581-6850
or via email to therapy@ats-stillwater.com**