REFERRAL INTAKE FORM

21630 Merchants Way
Katy, TX 77449
Phone: 832-230-1518
Fax: 281-741-7355

NEW PATIENT INTAKE FORM					Intake Date:
SERVICES REQUESTED	☐ Occupational Therapy		☐ Physical Therapy		☐ Speech Therapy
	☐ Aquatic Therapy		☐ ABA		☐ Lokomat/ Robotic Therapy

PERSONA INFORMATION						
Patient Name:		Date of Birth:		Gender:	☐Male ☐Female	
Street Address:		City:		State: TX	Zip code:	
Guardian Name:		Relationship to Patient:				
Phone Number:		Secondary Phone Number:				
Can we text you:	☐ Yes ☐ No	Gate Code if applicable:	N/A			
Primary Language:	☐ English ☐Spanish ☐ Other:					
Patient Availabilty:	☐All Day ☐ Morning ☐Afternoon ☐ After School ☐Other:					
Place of Treatment:	☐ Home ☐ Katy Clinic	Phone Number:				
Address of Treatment if other than home:						

DIAGNOSIS	
Code	Diagnosis Description

INSURANCE INFORMATION			
Primary Insurance:		Secondary Insurance:	
Insurance ID Number:		Insurance ID Number:	
Group Number:		Group Number:	
Policy Holder Name:		Policy Holder Name:	
Policy Holder DOB:		Policy Holder DOB:	
Provider Phone Number:		Provider Phone Number:	

REFERRAL/PHYSICAN INFORMATION						
PCP Name:		Address:				
Phone Number:		City:		State: Tx	Zip Code:	
Fax Number:		License Number:		Taxonomy Numer:		
Practice/Clinic Name:		NPI Number:				
Last well child check up:		Last Hearing screening:				

REFERRAL SOURCE			
Referral Source:		Referral Contact:	

COORDINATION OF CARE				
Other Medical Services:	☐ Nursing	☐ OT	☐ PT	☐ ST
Other:		Date of Discharge:		
Name of agency:		Phone Number:		

STAFFING NOTES			
Able to Staff:		Treating Therapist:	
Discipline staffed:		Evaluation Therapist:	

PATIENTS NOTES	
Additional Comments:	
Intake Information was taken by :	

12/21
Called to