Fax referral to 281-741-7355

Reliant
Pediatric Therapy Services

21630 Merchants Way, Katy, TX 77449 Call us at 832-230-1518

DEMOGRAPHICS

PATIENT NAME:		DOB:		SEX:	☐ MALE	☐ FEMALE	
ADDRESS:		CITY:		STATE:	TX	ZIP:	
HOME:		CELL:		WORK:		EXT:	
EMAIL:		PARENT/ GAURDIAN:					
PRIMARY LANGUAGE:	☐ ENGLISH	☐ SPANISH	☐ OTHER:				

INSURANCE

PRIMARY INSURANCE:		ID #:		SUBSCRIBER:	
EMPLOYER:		GROUP:		SUBSCRIBER DOB:	
SECONDARY INSURANCE:		ID #:		SUBSCRIBER:	
EMPLOYER:		GROUP:		SUBSCRIBER DOB:	

REFERRING SERVICES

	☐ SPEECH THERAPY	☐ FEEDING/DYSPHAGIA	☐ ABA
☐ EVALUATE AND TREAT	☐ OCCUPATIONAL THERAPY	☐ AQUATIC THERAPY	
	☐ PHYSICAL THERAPY	☐ NEURO REHAB (LOKOMAT/ RT300 SL/ SA FES/ ARMEOSPRING)	

WHEN REFERRING FOR SPEECH THERAPY, PLEASE PROVIDE HEARING SCREEN, WELL CHILD & ASQ OR PEDS

1ST DIAGNOSIS/ICD10:	/
2ND DIAGNOSIS/ICD10:	/
3RD DIAGNOSIS/ICD10:	/

REFERRING PHYSICAN

PHYSICIAN NAME:			CREDENTIALS: (MD / DO / NP / PA)			
ADDRESS:		CITY:		STATE:	TX	ZIP:	
OFFICE PHONE:		FAX:				
REFERRAL COORDINATOR:		NURSE IN CHARGE:				

BY SIGNING OF THIS REFERRAL, I AM PRESCRIBING MEDICALLY NESCESSARY SERVICES THAT WILL BE REVIEWS AND APPROVED WHILE PATIENT IS UNDER MY.

PHYSICIAN SIGNATURE: DATE: