THERAPY & CONSULTING SERVICES
Transforming Lives, One Family at a Time

Clinic Address: 529 Beacon Pkwy W Suite 101
Birmingham, AL 35209
Clinic, Daycares, Private Schools, Teletherapy, ALF/ILF, In-Home Visits

Speech/Occupational Therapy Outpatient Referral/Prescription

Patient Name: _____

Phone #: _____ Contact name and phone #: _____

Address: _____

DOB: _____ Sex: _____

Diagnosis(es): _____

☐ **Supporting Documentation Sent to Provider**

Primary Insurance and ID #: _____

Secondary Insurance and ID #: _____

☐ **For Medicaid patients: An official Medicaid referral (EPSDT form) must be included.**

Service(s) Requested (check all that apply):

- ☐ Evaluation and Treatment of Speech/Language/ Cognition/Voice
- ☐ Evaluation and Treatment of Dysphagia (Feeding/Swallowing)
- ☐ Occupational Therapy Evaluation and Treatment
- ☐ ABA
- ☐ Other (please specify): _____

Reason for referral/additional information/special requests:

_____

I hereby certify the medical necessity of the services listed above.

Physician Name: _____ Clinic Name: _____

Physician Signature: _____

Physician Phone #: _____ Physician Fax #: _____

Physician NPI: _____

FAX ALL THERAPY REFERRALS/PRESCRIPTIONS TO: 205-850-5571