MILESTONE THERAPY, INC.

OT/PT FORM

FAX COMPLETED FORMS TO: 704-843-9045

PATIENT INFORMATION:

Name: _____

DOB: _____ Sex: ❑ Male ❑ Female

HOW DID YOU HEAR ABOUT US?

_____

PARENT/GUARDIAN INFORMATION:

Name: _____ ❑ Parent ❑ Legal Guardian ❑ Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

INSURANCE INFORMATION:

Insurance Carrier: _____ Secondary Insurance: _____

REFERRING PHYSICIAN:

Practice: _____ Physician Name: _____

Phone Number: _____ Fax Number: _____

Address: _____ City: _____ State: _____ Zip: _____

PHYSICIAN'S ORDER:

REQUESTED THERAPY (Please check all that apply): ❑ Occupational Therapy ❑ Physical Therapy

Inital: _____ SKILLED OCCUPATIONAL THERAPIST TO EVALUATE AND TREAT AS NEEDED.

Inital: _____ SKILLED PHYSICAL THERAPIST TO EVALUATE AND TREAT AS NEEDED.

PLEASE DESCRIBE AREAS OF CONCERN: _____

_____

_____

_____

_____

PLEASE LIST ALL RELEVANT DIAGNOSIS CODES: _____ _____ _____

Physician's Name (Print): _____ NPI: _____

Signature: _____ Date: _____