



**REFERRAL FORM - PHYSICIAN'S PRESCRIPTION**

**When Kids Play, LLC**

1169 N. Burleson Blvd

Suite 107-225

Burleson, TX 76028

Main: 817-852-6707

FAX 817-887-4678

Client specialist direct line: 817-973-5047

**EMAIL: [sblanton@whenkidsplay.com](mailto:sblanton@whenkidsplay.com)**

**Please use this form to start your patient's therapy services at When Kids Play**

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Parent / Caregiver Name: \_\_\_\_\_  
 Primary Language spoken in the Home: \_\_\_ English \_\_\_ Spanish \_\_\_ Other  
 Address: \_\_\_\_\_ Suite / Apartment: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

MEDICAID # \_\_\_\_\_ MEDICAID HMO/MCO? \_\_\_ YES \_\_\_ NO TYPE: \_\_\_\_\_  
 OTHER INSURANCE? \_\_\_ YES \_\_\_ NO NAME OF INSURANCE: \_\_\_\_\_  
 Policy Holder Name: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_  
 Policy Group #: \_\_\_\_\_ ID#: \_\_\_\_\_  
 Chief Complaint: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_  
 Diagnosis & ICD-10: \_\_\_\_\_ onset: \_\_\_\_\_  
 Contraindications / Precautions: \_\_\_\_\_

**PHYSICIAN INFORMATION**

Physician name: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Clinic / Practice name: \_\_\_\_\_ Taxonomy #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City / State / Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax / email: \_\_\_\_\_

**RECOMMENDED THERAPY**

<b>SPEECH / LANGUAGE THERAPY</b>	<b>OCCUPATIONAL THERAPY</b>	<b>PHYSICAL THERAPY</b>
___ Evaluation Only	___ Evaluation Only	___ Evaluation Only
___ Evaluation & Treatment	___ Evaluation & Treatment	___ Evaluation & Treatment
___ Other _____	___ Other _____	___ Other _____

**PLEASE SIGN AND DATE SO THAT WE CAN START YOUR PATIENT'S CARE**

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_