CHAYAH
PEDIATRIC THERAPY

Referral Form

(Items with ** are required for processing)

Fax To: 713.456.2041 or
email: info@chayahtherapy.com

Patient Information | Reason for Referral

If Medical Records Cover Sheet is included, Patient information can be left blank	Priority: OT ☐ **ST** ☐ PT
Patient Name *(First, Middle, Last)*** Sex: ☐ Male ☐Female	**If Medically Urgent**, please describe:
Date of Birth**	Diagnosis/ICD 10**
Guardian Name ** Phone # ***	Clinic / Specialty
Address**	Additional info
City** Zip Code** State	
Interpreter Needed? Yes ☐ No ☐ Preferred Language:	

Referring Company Information

Referring Provider Name**				
Practice Name**				
Office Address**				City**
State**		ZIP Code**		NPI Number
Phone**	Fax**		Provider Specialty	

Documentation Requested

☐ Copy of Insurance Card

☐ Insurance Authorization Information (If required)

CHAYAH
PEDIATRIC THERAPY
www.chayahtherapy.com