Helping Hands Pediatric Therapy

470 South Hill Street Buford, GA 30518

Referral Worksheet

Reset Form Print Form

Patient Information

Name: (First) (Mi) (Last) Date of Birth:

Parent / Guardian: Phone Number:

Address: City: State: Zip:

Physician's Name: Office Phone:

Times your child is unavailable for therapy:

Comments / Remarks:

Insurance Information

Insurance Company:

Insured's Name: (First) (Mi) (Last) Date of Birth:

Insured's ID #: Insured's Group #:

Insured's Employer: Phone Number:

Plan Type: ◯ HMO ◯ PPO ◯ Other (Specify)

Medicaid #:

Babies Can't Wait Cost Participation: % Service Coordinator: Health District:

Therapy Information (to be completed by Helping Hands Pediatric Therapy personnel)

Therapy Will take place in: ☐ Clinic ☐ Home ☐ Day-Care ☐ Other (Specify) _____

Diagnosis: _____

Therapy Type: _____

Frequency: _____

Other Services Received: _____

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Please e-mail or print and fax form to (770) 932-5684 and mail original prescription to 470 South Hill Street Buford, GA 30518

Phone: (678) 482-6100 - Fax: (770) 932-5684