The Children's TherAplay Foundation, Inc.

New Patient Form – ALL FIELDS REQUIRED

Date: _____ How did you hear about Children's TherAplay? _____
Referral for (please check): □ Physical Therapy □ Occupational Therapy
Patient Name: _____ DOB: _____
Diagnosis: _____ Weight: _____ Height: _____
Can patient sit independently? □Yes □No Walk independently? □Yes □No
What therapies does patient currently receive? _____ Location: _____
Date of last PT/OT evaluation: _____ Location: _____

Preferred Times for therapy appointments: _____ AM _____ PM
□ Monday □ Tuesday □ Wednesday □ Thursday □ Friday (please check **ALL** options)

Family Goals for Patient:

Parent/Guardians: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell: _____ E-mail: _____

Referring Physician: _____
Physician's Medical Group: _____
Physician's Address: _____
MD Phone: _____ MD Fax: _____
Referring Therapist: _____ Phone: _____

Insurance: Please check ALL that apply

□ Medicaid □ Children's Special Health Care Services □ Self-Pay □ Private Insurance

Medicaid Case Manager: _____ Phone: _____ Fax: _____
Type of MCD: □ Traditional □ Waiver □ Risk Based Managed Care

Client's RID #: _____ Effective Date: _____

CSHCS: ID #: _____ Effective Date: _____

Private Insurance:
Company: _____
Insured's Name: _____ DOB: _____
Policy#_____ Group #_____
Provider Services Phone Number (on back of card) _____

Please be sure to inform us of ANY changes in your insurance.
Failure to do so may result in patient responsibility for the entire billable amount.

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