

The Children's TherAplay Foundation, Inc.





Date:	How did you hea	ar about Childre	en's TherAplay?	
Referral for (please check):	□ Physical Therap	y 🗆 Occup	ational Therapy	
Patient Name:			DOB:	
			Weight: Heigh	
Can patient sit independent	:ly? □Yes □No	Walk inde	pendently? □Yes □No	
What therapies does patient	t currently receive? _		Location:	
Date of last PT/OT evaluation	on:	Locati	on:	
Preferred Times for therapy	appointments:	AM	PM	
□ Monday □ Tuesday	□ Wednesday	□ Thursday	□ Friday (please check ALL option	s)
Family Goals for Patient:				
Parent/Guardians:				
Home Phone:	Cell: _		E-mail:	
Referring Physician:				
	MD Fax:			
Referring Therapist:	Phone:			
Insurance: Please check AI	LL that apply			
□ Medicaid □ Childre	en's Special Health (Care Services	□ Self-Pay □ Private Insurance	
Medicaid Case Manager:		Phone:	Fax:	
Type of MCD: □ Traditio				
Client's RID #:		Effectiv	ve Date:	
CSHCS: ID #:		Effectiv	re Date:	
Private Insurance:				
Company:				
			DOB:	
olicy# Group #				
Provider Services Phone N	umber (on back of ca	nrd)		

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.