



EAST COAST THERAPIES • THE THERAPY CONSORTIUM INC.

Pediatric Occupational, Physical & Speech Therapy Services

P.O. Box 1523, Little River, SC 29566 | Office: (843) 455-7505 | Email: therapyc1523@gmail.com



REFERRAL / INTAKE INFORMATION

1. REFERRAL & SERVICE DETAILS

Date of Referral:	_____	Location of Service:	☐ Home ☐ Clinic ☐ Daycare / School
Referral For:	☐ OT(Occupational Therapy) ☐ PT(Physical Therapy) ☐ ST(Speech Therapy)		
Referring Agency / Coordinator:	_____		
Coordinator Phone / Email:	_____		

2. CHILD & FAMILY INFORMATION

Child's Name:	_____	DOB:	_____	Gender:	☐ M ☐ F
SS#:	_____	Address:	_____		
Parents' Names:	_____	Email:	_____		
Primary Phone:	_____	Alt Phone:	_____		

3. CLINICAL REASON & PAYER SOURCE

Reason for Referral:	_____		
Diagnosis 1:	_____	ICD-10 Code:	_____
Diagnosis 2:	_____	ICD-10 Code:	_____
Payer Source / Medicaid #:	_____	MCO:	_____
Insurance Info / Policy #:	_____		
Physician / Doctor:	_____	Doctor Phone / Fax:	_____

Please complete this referral form and attach a prescription for requested services.

Direct Fax to:  (231) 625-4219

* Any medical history, previous evaluations, and related developmental records are greatly appreciated.