PERDUEWORKS
THERAPY GROUP

2001 N Loy Lake Rd Suite J

Sherman, TX 75090

Phone- 903-487-5520

Fax- 903-496-0004

Patient referral

Please complete the referral form and fax to (903)496-0004 or email referrals@perdueworkstherapygroup.com. A referral form is needed every 12 months for billing insurance purposes. This will be used as the provider order. Please send the patients H&P notes along with this referral.

Services needed *(circle one)*: **OccupationalPhysical Speech**

Therapist full name *(leave blank if unsure of provider name or NPI):* ____
NPI# ___________________________

____ **NPI#** ___________________________

____ **NPI#** ___________________________

Patient full name: ____

Patient DOB: ______________________ **Phone#:** ____

Parent/Guardian full name: ____

Mailing Address: ____

Insurance: ____

Subscriber ID & Group #: ____

Guarantor full name & DOB: ____

ICD-10: ____

Referring Provider name: ____

Referring provider signature: ____

Thank you for the referral

Statement of Medical Necessity

I, the undersigned, certify that the therapy services prescribed above are both reasonable and necessary for the patient's well-being. These services are medically necessary and are not considered routine in nature.

Referring Provider Signature: ____

Start Date: ______________________

Please attach a problem list or health history if multiple diagnoses apply.