

**THERAPY SOLUTIONS OF GEORGIA, INC.**  
3615 BRASELTON HIGHWAY · SUITE 103 · DACULA, GEORGIA 30019-5907

**REFERRAL WORKSHEET**

Date: \_\_\_\_\_

**PATIENT INFORMATION**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(First) (MI) (Last)

**Parent/Guardian:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**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:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(First) (MI) (Last)

**Insured's ID #** \_\_\_\_\_ **Insured's Group #** \_\_\_\_\_

**Insured's Employer:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Plan Type**  HMO  PPO  Other (specify): \_\_\_\_\_

**Medicaid #** \_\_\_\_\_

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

**THERAPY INFORMATION** (to be completed by Therapy Solutions of Georgia, Inc. personnel)

**Therapy will take place in**  Clinic  Home  Day-Care  Other (specify): \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Therapy Type:** \_\_\_\_\_

**Frequency:** \_\_\_\_\_

**Other Services Received:** \_\_\_\_\_

Please fax completed form to (678) 377-9609 and mail original prescription to 3615 Braselton Highway, Suite 103, Dacula, GA 30019-5907.

P H O N E : ( 6 7 8 ) 3 7 7 - 9 6 3 4 · F A X ( 6 7 8 ) 3 7 7 - 9 6 0 9