



Southland Therapy Services

Patient Referral Information Form

Please complete the requested information below and Fax to our office at 912-335-2377. Please also fax over copy of insurance card (front & back), any progress notes, demographics and prescriptions for "Speech/OT/PT therapy: evaluation and treat as indicated: Dx (include diagnosis)" Thank you in advance for referring this patient to our practice!

Referred for: Speech OT PT Date: _____ Diagnosis: _____
Referring physician: _____ Primary Physician: _____
Reason for referral: _____

Patient Information:

Patient Name: _____ Sex: Male Female
DOB: _____ Patient SS#: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Guardian's name: _____ Relationship: _____
Home phone #: _____ Work # _____ Cell# _____

**** Medicaid children will receive an evaluation and/or treatment faster when referred directly to us- we accept all Medicaid.**
___ Medicaid Fee For Service (birth – until school full time)
___ Medicaid Community Health Solutions or Palmetto Physician Connections (birth – until school full time)
___ Medicaid MCO: Select Health / Absolute TC/ UH Community/ Bluechoice (birth up to what the MCO will allow)
___ Private Pay -STS will bill insurance but patient is responsible for Evaluation (Rate of \$100.00) (If patient is < 3yrs., Evaluation is faxed to BabyNet referral dept.)

Primary Insurance Information:
Payor: _____ Plan _____ Phone #: _____
Medicaid/Policy# _____ Group# _____

Policy Holder Information:
Subscriber Name: _____ Relationship to patient: _____
Subscriber DOB: _____ Gender: _____ Employer: _____

Secondary Insurance Information:
Payor: _____ Plan _____ Phone #: _____
Medicaid/Policy# _____ Group# _____

Policy Holder Information:
Subscriber Name: _____ Relationship to patient: _____
Subscriber DOB: _____ Gender: _____ Employer: _____

For office use:
Patient has been notified/scheduled: Y N Appointment Date/Time: _____
Additional Comments: _____