Pediatric Home Health Care

Please fax your referrals to:

Colorado: 855-715-3504
Idaho: 855-631-4041
Texas: 877-300-7394
Oregon: 888-901-2288

Patient Name: **DOB:** M F

Street Address: Zip Code:

Treating Address:
(if different from home) Day-time After-school

Parent/Guardians:

Home Phone: Emergency Contact/Relationship:

Primary Language: English Spanish Other:

Medicaid: Medicaid ID #:

Insurance: Insurance ID #:

Evaluate & Treat Disciplines: Speech Therapy Occupational Therapy Physical Therapy Feeding/Dysphagia Language/Cognitive

Clinic/Physician Information:

Address:

Phone: Fax:

Referral/Care Coordinator: Date:

Date of last well child exam:

PHYSICIAN REFERRAL ONLY (complete below):

I certify that this patient is under my care and authorize the evaluation and treatment of the patient if deemed necessary.

Physician's Name (printed) ____________________________

Physician's Signature: ____________________________