



Pediatric Home Health Care

Please fax your referrals to:

Colorado: 1-855-715-3504

Florida: 1-954-538-1414

Idaho: 1-855-631-404

Maryland: 1-800-803-8356

Oregon: 1-888-901-2288

South Carolina: 1-843-278-8599

Texas: 1-877-300-7394

Virginia: 1-800-803-8356

Washington, D.C.: 1-202-742-4056

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: _____

Office Phone Numbers: Colorado: 844-757-7450 | Florida: 954-538-8588 | Idaho: 877-200-8152

Maryland: 703-679-7837 | Oregon: 877-755-8940 | South Carolina: 843-894-7374

Texas: 866-919-3240 | Virginia: 703-679-7837 | Washington, D.C.: 202-810-6167

www.kidscarehomehealth.com