Physician Referral

Child's name:_______________________________________DOB:______________Gender:________

Child's SSN#:________________________Interpreter:____________Language:______________________

Parent/guardian:____Phone: (   )______________

DCS caseworker:___________________________County:______________Phone: (   )______________

Address:____
Street City State Zip

Insurance:____Authorization:______________________

MEDICALLY RELATED DIAGNOSIS:____________________________________ICD-10:______________

Services Requested

Please check service type requested

___Speech/language evaluation & treatment

___Physical therapy evaluation & treatment

___Oral motor/feeding therapy evaluation & treatment

___Occupational therapy evaluation & treatment

Therapy restrictions or comments:____

Physician signature:____Date:____________________

Print physician name:______________________________________Phone number:______________

Physician to follow care:____

*****Complete information will promote timely scheduling. Thank you.*****

Return by Fax to: 865.693.3941

Emory Center
207 E. Emory Road
Powell, TN 37849
Ph: 865.343.6983

Rehabilitation Center
1025 Children's Way
Knoxville, TN 37922
Ph: 865.690.8961