STEP THERAPY PEDIATRICS

Denver Tech Center |Aurora

Need Assistance?
Physician Helpline: 720-439-9100 Ex 3

Occupational Therapy · Physical Therapy · Speech Therapy

Referral Request Form

(Items with ** are required for processing)
FAX to: 855-283-4752 or EMAIL to: intake@steptherapypediatrics.com

Patient Information	Reason for Referral
If submitting an electronic referral- electronic signature and date of referral are required for prompt processing.	**One Referral is accepted per discipline. Please fill out additional referral forms if referring for more than one service.**
Name: First, Middle, Last** **Sex: ☐ Male ☐ Female**	**Evaluate and treat as indicated for: ** (Check 1 per referral)** **☐ Occupational Therapy** **☐ Physical Therapy** **☐ Speech Language Pathology (Speech Therapy)**
Date of Birth **	**ICD10** (must include diagnosis number)**
Caregiver First, Last Name **	**Primary Concerns:**
Phone Number **	**Primary insurance: _____** **Member ID: _____** **Secondary insurance: _____** **Member ID: _____**
Address**	**Location Requested** **☐ Greenwood Village (DTC) ☐ Aurora**
City State ZIP**	**Interpreter Needed? ☐ Yes ☐ No** **Preferred Language:_____**

Referring Provider Information

Referring Provider Name ** *(print only)*	**Practice Name**** *(print only)*
Office Address **	**PCP NPI ****
Phone **	**Fax****

Referring PCP Signature: ** (Legible Signature required for processing) (Electronic Signature is accepted)	**Date:****