Pediatric Therapy & Audiology
Referral Form

Phone: (256) 265-7952 Fax: (256) 265-7953

Patient name: _____ **DOB:** _____

Parent/Guardian: _____

Phone numbers: _____

Diagnosis: _____

Precautions: _____

Concerns at time of referral: _____

Does this patient need an interpreter? ◯ Yes ◯ No

- ☐ Physical Therapy/evaluate and treat
- ☐ Aquatic Physical Therapy/evaluate and treat
- ☐ Occupational Therapy/evaluate and treat
- ☐ Speech Therapy/evaluate and treat
- ☐ Feeding Therapy/evaluate and treat with Speech Therapist
- ☐ Modified Barium Swallow Study with Speech Therapist
- ☐ Audiology / evaluate and treat *(mark one below)*
  - ◯ Refer on newborn hearing screen
  - ◯ Did not receive newborn hearing screen
  - ◯ Failed office/school screening
  - ◯ Risk factors/syndrome associated w/ hearing loss
  - ◯ Family concerns/family hx of hearing loss
  - ◯ Speech concerns
  - ◯ Known hearing loss
  - ◯ Use hearing aids/cochlear implants
- ☐ Audiology/Sedated ABR

Physician/practitioner name: _____ **Phone:** _____ **Fax:** _____

Physician/practitioner original signature: _____ **Date:** _____ **Time:** _____

FAX completed form to (256) 265-7953. Please attach demographic sheet if possible.

Women & Children
HUNTSVILLE HOSPITAL

PHYORD

2-23-12

ALABAMA MEDICAID REFERRAL FORM
PHI-CONFIDENTIAL

Today's Date _____

Date Referral Begins _____
(If different from above)

Important NPI Information
See Instructions

MEDICAID RECIPIENT INFORMATION

Recipient Name	Recipient #	Recipient DOB
Address	Telephone # with Area Code _____ Name of Parent/Guardian _____	

PRIMARY PHYSICIAN (PMP) INFORMATION

Name	
Address	
Telephone # with Area Code _____	
Fax # with Area Code _____	
Email _____	
NPI # _____	
Medicaid Provider # _____	
Signature _____	

SCREENING PROVIDER IF DIFFERENT FROM PRIMARY PHYSICIAN (PMP)

Name	
Address	
Telephone # with Area Code _____	
Fax # with Area Code _____	
Email _____	
NPI # _____	
Medicaid Provider # _____	
Signature _____	

TYPE OF REFERRAL

☐ Patient 1st	☐ Lock-in
☐ EPSDT Screening Date _____	☐ Other
☐ Case Management/Care Coordination	

LENGTH OF REFERRAL

Referral Valid for _____ month(s) or _____ visit(s) from date referral begins.

REFERRAL VALID FOR

☐ Evaluation Only	☐ Treatment Only
☐ Evaluation and Treatment	☐ Hospital Care (Outpatient)
☐ Referral by consultant to other provider for identified condition (cascading referral)	☐ Performance of Interperiodic Screening (if necessary)
☐ Referral by consultant to other provider for additional conditions diagnosed by consultant (EPSDT Only)	

Reason for referral by PMP	**Other conditions/diagnoses identified by PMP**

CONSULTANT INFORMATION

Consultant Name	
Address	Consultant Telephone # with Area Code

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to Primary Physician (PMP).

Findings should be submitted to Primary Physician (PMP) by

☐ Mail ☐ E-mail ☐ Fax ☐ In addition, please telephone