



REFERRALS ONLY

Fax: 888 244-5493
www.compleatkidz.com

Patient Name: _____ DOB: _____

Diagnosis: _____

Address: _____

Parent/Guardian Name: _____

Phone: _____ Email: _____

Evaluate and Treat for the selected Therapies/Services (check all that apply):

Physical Therapy

Occupational Therapy

Speech Therapy

Required attachments:

Patient's demographic sheet

Physician notes pertaining to diagnosis.

ABA (RB-BHT) with Autism Screen for ABA Services

Evaluating therapist may add any of the above therapies/services to these orders if their assessment indicates a need to include them to fully address the patient's needs.

Specific Requests: Interpreter _____ Orthotics Swallowing
(Language)

ABA Home Based Services

Special Instructions: _____

Carolina Access Medicaid # (Must be Completed) _____

PCP NPI # _____

Group NPI # _____

Insurance _____

ID # _____

Group # _____

Phone # _____

Requesting Clinic

Name _____

Address _____

(Physician - Printed)

(Person Requesting Services/Appointment)

(MD or DO signature - Required for autism screen)

(Date)