REFERRAL FORM

Please complete the details below to refer to our office.

Patient name: ________________________________ DOB: ____/______/______

This referral is for: ☐ ***Physical Therapy*** ☐ ***Occupational Therapy***

☐ ***Speech Therapy*** ☐ ***Counseling***

Reason for referral:

☐ *Fine motor concerns*
☐ *Gross motor concerns*
☐ *Sensory Processing*
☐ *Behavior concerns*
☐ *Coordination*
☐ *Developmental Delay*
☐ *Speech Delay*
☐ *Other:* ____

Diagnosis: ____

Contact Info:

Caregiver's name: ____

Phone numbers: ____

Address: ____

Insurance: ____

Referred by: ________________________________ at ____________________

Please fax to Pediatric Advanced Therapy at 704-799-6825.
Thank you for your continued referrals!

134 Infield Court Mooresville, NC 28117 • 2102 Cambridge Beltway Dr Ste E, Charlotte, NC 28273
1777 Old Earnhardt Rd Kannapolis, NC 28083
PH: 704-799-6824 • FAX: 704-799-6825