158 State St. Meriden, CT 06450
Phone: (203) 237-7835 / Fax: (203) 237-9187
www.Easterseals.com/waterburyct

Outpatient Referral Form

In order to comply with our billing criteria and documentation procedures we ask that the referring physician sign this prescription and provide a diagnosis along with ICD-10 codes, medication list and last office note/medical history.

Please fax the following to Easterseals Medical Rehabilitation Program

1. Completed and Signed Prescription
2. Include diagnosis code on script
3. Include patient insurance information
4. Last Office Note / Medical History if available

Patient Information: Date: ___________________________

Name: ____ DOB: _______________

Address: ____

Home Phone: ______________________ Cell/Work Phone: ______________________

Patient Primary Insurance Plan: ____

ID Number: ______________________ Group Number ______________________

Patient Secondary Insurance Plan: ____

ID Number: ______________________ Group Number ______________________

Prescription For:

Physical, Occupational, and Speech Therapy Evaluation & Treatment

Diagnosis: ____________________________ ICD-10 Codes: ______________________________

Physician's Name (**Print**): ____

Physician's Signature: ____ Date: __________________

Physician's Address: ____

NPI # ____ Frequency:

Phone: _____________________________________ Fax: ____________________________________