Last date seen by PCP _____

Last WCC date _____

Step by Step
Home Care and Therapy, PLLC
4211 Gardendale, Suite A200
San Antonio, TX 78229
(210) 615-7837
Fax: (210) 615-7848

Daytime _____

Afterschool _____

Date of Referral

REFERRAL & ORDERS FOR HOME HEALTH SERVICES

Patient Name (Last, First, Middle)			Primary Language ☐ English ☐ Spanish
Address (Street #)	City, State		Zip Code
Birth Date	Sex ☐ M ☐ F	Insurance Provider	Insurance #
Parent's Name		Alternate Contact Name	
Parent's Telephone #		Alternate Contact Telephone #	

Name of Physician (Last, First)		Telephone#	Fax #
Physician NPI #		Physician License #	Physician UPIN #
Address of Physician	City, State		Zip Code

☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy
☐ NMES-VitalStim Therapy
☐ Feeding/Swallowing/Dysphagia Treatment

Hearing Screening:
☐ Attempted & **Passed**
☐ Attempted & **Non-Compliant**

ICD-10-CM Diagnosis

Other: _____

PRIMARY DIAGNOSIS

☐ F80.0 Phonological Disorder
☐ F80.1 Expressive Language Disorder
☐ F80.81 Childhood Onset Fluency Disorder
☐ F80.89 Other Developmental Dis of Speech & Language
☐ R62.50 Unspecified Lack of Expected Normal Physi. Dvl
☐ R13.0 Dyphagia
☐ R27.9 Unspecified Lack of Coordination
☐ R26.0 Ataxic Gait
☐ M43.6 Torticollis

SECONDARY DIAGNOSIS

☐ F84.0 Autistic Disorder
☐ G80.8 Other Cerebral Palsy
☐ Q90.9 Down Syndrome, Unspecified
☐ F90.1 Attn-Deficit, Hyperactive Type
☐ F90.0 Attn-Deficit, Inattentive Type

Social Service / Case Manager (if applicable) - include address, telephone and fax

Additional Orders / Treatment Instructions / Precautions / Related Comments

Authorizing Physician Signature — Date Signed

By signing: Physician allows Step by Step Home Care and Therapy to perform an Evaluation on the Patient and if patient is deemed needing — Speech Therapy, Occupational Therapy, Physical Therapy or Feeding Therapy allows us to begin providing Patient services prior to Physician receiving / signing Evaluation if authorization is approved by payor.