THERAPY NETWORK OF GEORGIA

Patient Intake Form

Please Fax To Therapy Network
Authorization Department: (855) 597-2697
Phone Inquiries: (855) 825-7818

Facility Name:		Tax ID #:
Facility Address:		
Phone:	Fax:	
Treating Therapist Name (Print):		NPI:
Patient Name:	Patient ID:	Date of Birth:
Patient County:	PCP Name:	Health Plan: **WellCare**
Med. Dx:		ICD Code(s):
Treatment Dx:		ICD Code(s):
Other info, if surgery, list procedure:		
Date of Surgery:	For Dx: CVA, list date of CVA:	
Member's Plan of Care has been submitted to ordering Provider. ☐ Please check box to confirm.	Ordering Provider will be notified when therapy has been completed (Member discharged), or Therapy was stopped ☐ Please check box to confirm.	

Fill out separate form for each discipline:

☐ Physical Therapy	Evaluation Date:
☐ Occupational Therapy	Evaluation Date:
☐ Speech Therapy	Evaluation Date:

If a child is enrolled in the following programs, please indicate in the space provided and attach the IFSP/IEP as applicable.

☐ (BCW) Babies Can't Wait — Please provider IFSP (dated within the last 6 month)

☐ (CIS) Children Intervention Services — Please provider IEP (dated within the last 6 month and Provider Prescription)

Deficits found, Test(s) Administered and: 1) Standard Score (preferred), or 2) Age Equivalence, or 3) Performance level

For Transition requests (Members in active Therapy on TN contract start date:

Date of last Evaluation:	# visits completed:	Date of Last visit:

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