THERAPY NETWORK OF FLORIDA

Patient Intake Form

For inquiries or status of pending requests, call:	Fax this request to:
1 (888) 550-8800 x1	1 (855) 410-0121

☐ Routine ☐ Urgent (please indicate Medical reason in the Additional Information section below)

Facility / Group Name		TIN Number	
Facility / Group Address (where services will be rendered)		Facility / Group NPI	
City		State	Zip
Contact Person	Phone	Fax	
Treating Therapist Name (rendering)		Treating Therapist NPI	
Referring Provider Name		Referring Provider NPI	
Patient Last Name	Patient First Name	Patient ID	
Patient County		Patient Date of Birth (mm/dd/yyyy)	

Line of Business ☐ **Medicare** ☐ **Medicaid** ☐ **Medicaid Healthy Kids**

Place of Service ☐ **Office (11)** ☐ **Independent Clinic (49)** ☐ **Other [__ __]**

Primary Diagnosis Description

☐ **ICD-10**	ICD Code 1	ICD Code 2	ICD Code 3	ICD Code 4

If Status Post Surgery, List Procedure

Date of Surgery (mm/dd/yyyy)	For Cerebral Vascular Accident (CVA), list Date of CVA (mm/dd/yyyy)

☐ Please check box to confirm	☐ Please check box to confirm	☐ Please check box to confirm
Member's Plan of Care has been submitted and approved by ordering Provider and the frequency and duration are: _____ times/ per week _____ number of weeks	The servicing provider has reviewed the approved Plan of Care with the Enrollee including the frequency and duration, and will provide these services.	Ordering Provider will be notified when therapy has been completed and whether the goals have been achieved (Member discharged) or Therapy was stopped.

FILL OUT SEPARATE PATIENT INTAKE FORM FOR EACH DISCIPLINE

☐ **Physical Therapy** ☐ **Occupational Therapy** ☐ **Speech Therapy** Evaluation Date (mm/dd/yyyy):

TEST SCORE	Test Used	Test Results (Standard Deviation)	Test Result (Age Equivalency) ____ _____ ☐ **Month** ☐ **Year**

Note/Comments

Additional Information: