P.A.T. Kids
Pediatric Advanced Therapy

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***

☐ ***Psychological Testing***

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!

PH: 704-799-6824 • FAX: 704-799-6825