LEGENDS

HOME THERAPY

Therapy Referral Form

Patient Name:_____DOB:_____SSN#:_____

Primary Phone:_____Secondary Phone #:_____Email:_____

Medicare/Primary Insurance #:_____Secondary Insurance Policy #:_____

Address:_____

Diagnosis / Reason for referral:

_____

_____

_____

☐ PT to Evaluate and Treat:_____

☐ OT to Evaluate and Treat:_____

☐ SLP to Evaluate and Treat:_____

_____ _____ _____

Physician / NP /PA Signature **Printed Name** **Date**

NPI# _____**Phone**_____ **Address:**_____

Please fax completed form to (847) 750-5500 or email to intake@legandsht.com