Bright Start LLC

Speech Therapy Referral

Please send to Rupal Patel

Phone: 803-667-7835 Fax: 803-897-8179 Email: rupalpatel@brightstartsc.com

Child's Name:_____ DOB:_____

Parent/Guardian: _____

Address: _____ Home #: _____

_____ Other #: _____

County:_____ Gender: Male Female

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY)

Medicaid Name: _____

Medicaid #:_____

Name of Physician on Script:

_____

Practice Name: _____

Practice Address:

_____

_____

Phone #: _____

Fax #: _____

Private Insurance Name: _____

Policy Holder Name: _____

Policy Holder's DOB:_____

Member #:_____

Group #: _____

Medical Claims Address and Phone #:

_____

_____

_____

_____

PHYSICIAN'S SCRIPT INCLUDED? Yes No

HAS CHILD RECEIVED SPEECH BEFORE? Yes No IF YES: Attach recent Evaluation and Discharge Summary

Comments/Reason for Referral:

_____

_____

Referred By:_____ Contact #: _____ Date: _____