Speech Therapy Referral

Please send to Rupal Patel

Phone: 803-227-3757 Fax: 803-929-1418 Email: rupalpatel@brightstartsc.com

Child's Name:____________________________________ DOB:_____________________________

Parent/Guardian: ____

Address: _______________________________________ Home #: _________________________

____ Other #: _________________________

Gender: Male Female

Child's Social Security #: _______________ County:________________________

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY)

Medicaid Name: _______________________ Private Insurance Name: _______________________

Medicaid #:___________________________ Policy Holder Name: ___________________________

Name of Physician on Script: Policy Holder's DOB:___________________________

_____________________________________ Member #:___________________________________

Practice Name: ________________________ Group #: ____________________________________

Practice Address: Medical Claims Address and Phone #:

___________________________________ ____

___________________________________ ____

Phone #: ___________________________ ____

Fax #: ______________________________ ____

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: __________________