All Care Therapies
OF GEORGETOWN

Occupational Therapy • Physical Therapy • Speech Therapy

Name: _____ DOB: _____

Phone Number: _____ Cell Provider: _____

E-Mail Address: _____

Referral Date: _____Insurance: _____

Diagnosis: _____

Treatment Plan (check all appropriate items):

____ Physical Therapy Evaluate and Treat

____ Occupational Therapy Evaluate and Treat

____ Speech and Language Evaluate and Treat

____ Dysphagia/Feeding Difficulties Evaluate and Treat

Precautions/Contraindications:

_____

_____

Remarks: _____

_____

Physician Name: _____

Physician Signature: _____

Please fax completed form to:
512-375-3291 or 512-498-0989