720 Old Cherokee Rd. Lexington, SC 29072
(p) 803-490-0960 (f) 866-464-4298

CAPITAL CITY THERAPY GROUP

Pediatric Therapy Referral Form

Child's Name: _____ Date of Referral _____

Date of Birth: _____ Sex: **M / F**

Parent/Guardian: _____ Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Pediatrician: _____ Phone: _____

Insurance Type(s): (Primary) _____ /(Secondary) _____

Insurance Number(s): _____ / _____

Reason for Referral: _____

_____

_____

Services: **Speech Therapy** **Occupational Therapy** **Feeding/Swallowing Therapy**

Referring Provider's Signature: _____ Date: _____

Print Name: _____

Clinic Name:_____ Phone: _____

Please fax this form to: (866) 464-4298

Or email to CCtherapygroup@gmail.com *Office manager, April Newsome, will contact patient's guardian with further instructions on appointment setting*