Fountain Therapeutic Center **www.speechservicesoftexarkana.com**

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INITIAL INTAKE INFORMATION

ST_____ OT_____ PT_____

NAME: **CONCERN**

DOB:

PARENTS:

ADDRESS:

PHONE #: _____

PHYSICIAN: Dr._____ Phone:_____

INSURANCE INFO:

TX OR AR MEDICAID:

ARSSI & TXSSI

EVALUATION DATE: M T W Th F _____ TIME:_____

DATE TO SEND CASE HISTORY / MAP: _____

SENT CH / MAP ON _____

DATE SENT REFERRAL LETTER TO PHYSICIAN _____

DATE REFERRAL WAS RECEIVED HERE _____