Northwest Florida ENT

561-495-8000
Fax: 561-495-8001

www.audiology.pro eardoc@audiology.pro 5130 Main Blvd., Suite B4 - Delray Beach, FL 33484

***PLEASE COMPLETELY FILL OUT TOP SECTION OF FORM**

THERAPY REQUEST FORM

Date: 12/30/12 Faculty Clinical Instructor: _____

THERAPY RECOMMENDED FOR: (Semester)_____ (Year) _____

Name: Robert L. Smith Date of Diagnosis (If New): _____
Address: 4506 45th WY, Mangonia Park, FL 33407

Business Phone: _____ Home Phone: (333) 444-5555 E-mail: robert@gmail.com

Age: _____ Date of Birth: 3/2/43
Year Months

Parent (or other), if client is a child: _____

Enrolled in therapy elsewhere? ____ Yes ____ No Where: _____

AUTHORIZED REPRESENTATIVE (SEE HIPAA FORM IN MANUAL, APPENDIX D) COMPLETE THIS FORM IF SOMEONE OTHER THAN THE LEGAL GUARDIAN WILL ACCOMPANY PATIENT TO THERAPY.

Diagnosis Code: _____ Program Type: _____

Describe nature of proposed treatment. Be specific in denoting kinds of activities or special instructions which will need to be taken into consideration for therapy: _____

_____

Is grouping recommended? If not, could it be considered? _____

Days/Times that **will not**, under any circumstances, be acceptable for therapy: _____

_____

==========

Complete in pencil only

Schedule Assigned: _____ _____
Days Time

_____ _____
Room Assignment Faculty/Clinician

Grouped with: _____

☐ Above rejected. Date: _____ Reason: _____

☐ Schedule confirmed. Date: _____ By: _____

==========

☐ Request scheduling authorization. _____

_____

Director's Initials: _____ Date: _____ Bookkeeper's Initials: _____ Date:_____