Communication Cottage Therapy LLC
5000 Highway 17 Bypass South
Myrtle Beach SC 29588
PHONE: (843) 252-0033
FAX: (843) 582-0259

# Evaluation Request/Referral Form

Name of Child Being Referred: _____

Child's Date of Birth: _____

Child's Gender: _____

**Services Needed (circle):**

Speech Therapy Feeding TherapyOccupational Therapy Physical Therapy

Reason for Referral: _____

**Service Location (circle):**

Home Cottage (clinic) Daycare Private School

Name of Daycare (if applicable): _____

**Service Address:**

Street: _____ City: _____ State: _____ Zip: _____

**Has the Child Received An Evaluation Previously? (circle) Yes No**

If yes, please email previous evaluations and discharge summaries to
admin@communicationcottagetherapy.com

**Referring Agency/Case Coordinator:** _____

**Parent/Caregiver Name:** _____

**Parent/Caregiver Phone:** _____

**Parent/Caregiver Email:** _____

**Please Indicate All Insurance Information Below** (primary and secondary/tertiary if applicable):

_____

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**Email** admin@communicationcottagetherapy.com a copy of your insurance card (front/back)

**If private/commercial insurance, is the family willing to deny insurance to bill babynet directly? (circle)**
**Yes No**

**Doctor's Name: _____**

**Doctor's Phone: _____**

**Doctor's Fax: _____**

**Has a Doctor's Script been obtained for services requested? ? (circle) Yes No**

**If Yes please email the script to admin@communicationcottagetherapy.com**

**I understand that by completing this form it doesn't guarantee availability with a provider immediately. (circle) Yes No**

**I understand that I will be contacted when an available time slot opens up but that I can follow up by email: hello@communicationcottagetherapy.com (circle) Yes No**

**I will do my best to notify Communication Cottage Therapy if I am no longer in need of services/if this child gets picked up by another agency. (circle) Yes No**