Project Wiggles and Giggles

Mailing: P.O. Box 230471, Montgomery, AL 36117
Physical: 5921 Carmichael Road, Montgomery, AL 36117 Phone: 334-264-8887
Fax:334-264-1605

Referral Order Form

Patient Name: _____ DOB: _____

Parent/Guardian Name: _____

Patient Primary Phone: _____ Alternate Phone: _____

Primary Insurance: _____ Secondary Insurance: _____

Chief Complaint _____

Services Requested

☐ Physical Therapy/Eval. ☐ Occupational Therapy/Eval. ☐ Speech/Language Therapy/Eval.

☐ Autism Evaluation to include Occupational and Speech Evaluations

Requested Frequency

☐ _____ visit (s) per week for _____ weeks ☐ _____ for _____ weeks

PLEASE NOTE – Post Op referrals require Operative Report, Protocols, & Current Medication

Post-OP Outpatient for _____

Outpatient to begin after the following date _____

Referring Provider Name _____ Provider NPI _____

Facility _____ Phone _____

Address _____ Fax _____

I certify that the therapy services are medically necessary and approved by me. Please send Medicaid EPSDT along with prescription.

Provider Signature _____ Signed Date _____

Certification Effective Date _____

The Arc
Madison County Inc.