CORTEX INITIATIVE

Comprehensive Therapy.
Individualized Care. Meaningful Outcomes.

OUTPATIENT THERAPY REFERRAL / ORDER

FAX REFERRALS: (833) 924-0333 | Phone: (757) 780-8146 | info@cortexinitiative.com

1. PATIENT INFORMATION

Patient Name: _____ DOB: _____

Parent/Guardian Name (if applicable): _____

Patient Phone: _____

2. REFERRAL / ORDER

Diagnosis / ICD-10 Code(s): _____

_____

Reason for Referral / Clinical Concerns: _____

_____

_____

_____

ORDER

☑ **Evaluate & Treat**

(Evaluation is included as part of the initial plan of care)

Special Instructions (if applicable):

_____

_____

_____

3. SERVICES REQUESTED

Please select discipline(s) and location(s) below.

CHESAPEAKE CLINIC
Hickory/Great Bridge
Pediatric services offered here

- ☐ Pediatric Speech Therapy — Ages 0–18
- ☐ Pediatric Occupational Therapy — Ages 0–18
- ☐ Adult Speech Therapy — Ages 18+
- ☐ Adult Occupational Therapy — Ages 18+

VIRGINIA BEACH CLINIC
Town Center
Adult services offered here

- ☐ Adult Speech Therapy — Ages 18+
- ☐ Adult Occupational Therapy — Ages 18+
- ☐ Adult Neuro Physical Therapy — Ages 18+
  Focus: Neuro Rehab • Balance • Vestibular • Gait & Mobility • Parkinson's • TBI • Stroke & Other Neurological Conditions

If you are unsure which service is most appropriate, please select all that apply.

4. REFERRING PROVIDER INFORMATION

Referring Provider Name: _____ NPI: _____

Practice / Organization: _____

Phone: _____ Fax: _____

5. PROVIDER SIGNATURE

Signature: _____

Date: _____

COMMENTS / ADDITIONAL INFORMATION:

_____

_____

_____

Please attach relevant clinical notes and insurance information if available.

A referral must be in place and received prior to the first visit.