Integrity
REHAB + HOME HEALTH

HOME HEALTH CARE
FAX: 254.628.7905
CALL: 254.628.7900

OUTPATIENT THERAPY
FAX: 254.526.8604
CALL: 254.699.3933
EMAIL: AUTHORIZATIONS@INTEGRITYREHAB.NET

Submitting referrals for Therapy and/or Home Health

1. **Complete Referral**. Physician/Provider may use this form or other preferred method to fill out the referral information.
2. **Attach Demographics**. Physician/Provider must include patient demographics, including front & back of insurance card.
3. **Send to Integrity**. Physician/Provider may send the referral and demographics via fax, email, or with the patient.
4. **Process & Schedule**. Integrity will verify insurance benefits and contact patient within 1-2 days.
5. **Begin Treatment**. Integrity staff will work hand-in-hand with patients to help them get better, faster.

EVALUATE AND TREAT AS INDICATED

☐ **URGENT:** Evaluate ASAP ☐ **ROUTINE:** Evaluate within 5 Business Days

PATIENT NAME: _____

PATIENT PHONE: _____ DATE OF BIRTH: _____

MEDICAL DIAGNOSIS: _____

☐ **PT/OT**
☐ **SLP**
☐ **Nursing**
☐ **Pelvic Rehab**

☐ **Home Health**
BELL, CORYELL, LAMPASAS, WILLIAMSON COUNTIES

☐ **Salado Clinic**
213 MILL CREEK DRIVE, SUITE 195

☐ **Killeen Clinic**
5302 JANELLE DR.

☐ **Harker Heights Clinic**
560 E. CENTRAL TX EXPY, SUITE 108

☐ **Copperas Cove Clinic**
181 W. HWY. 190, SUITE 7

SPECIAL INSTRUCTIONS / PRECAUTIONS

SURGERY TYPE/DATE/DESCRIPTION, PREFERRED TREATMENT PROTOCOL, ETC.

PHYSICIAN/PROVIDER PRINTED NAME: _____

PHYSICIAN/PROVIDER SIGNATURE: _____ DATE: _____

Most Insurances Accepted. For a complete list or to request additional copies of this referral form, please visit us online.