SPICE INTAKE INFORMATION

CHILD NAME _____

DATE OF BIRTH _____ SEX: ____ MALE ____ FEMALE

PARENT/GUARDIAN NAME(S) _____

ADDRESS/APT. # _____

CITY/ZIP _____ EMAIL _____

PHONE _____ PHONE _____

Referral made by: _____

Reason for referral _____

_____

SERVICES

Type of therapy services requested from SPICE: ____ OT ____ PT ____ SPEECH

Is your child currently receiving therapy services? ____ Yes ____ No

If so, where? _____

Has your child received therapy services in the past? ____ Yes ____ No

If so, where? _____

Medical Information

Child's primary care physician _____

Phone number:_____

Diagnosis_____

List any medications _____

SPICE INTAKE INFORMATION PAGE 2

Birth/Health History_____

_____

_____

_____

_____

SCHOOL INFORMATION

SCHOOL NAME _____

Phone number _____

ADDRESS _____ CITY/ZIP _____

PAYMENT FOR SERVICE

Payment method will be: ____ Self ____ Insurance ____ DSCC ____ IDPA
(Please fill in the details regarding funding sources on the Financial Agreement form enclosed.)

NOTE: SPICE requires preauthorization from DSCC, IDPA and Insurance prior to starting therapy. Please discuss authorization with your DSCC or IDPA caseworker, or insurance provider.