



Thrive
 Pediatric Therapy & Family Services

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 www.ThrivePediatricTherapySC.com

Referral Form

Referral Source Information (Who is referring: Doctor, Early Interventionist, parent, etc.)	Name:
Phone:	Company Name (if applicable):
Reason for Referral: ST OT PT	

Child's Information	Name:	
DOB:	SS#:	Sex:
Doctor's Name:		

Parent/ Guardian Information	Name:
Phone:	Email:
Address:	

Payer Source	Self Pay (no insurance, out of pocket): Y N
Medicaid: Y N	Medicaid #:
	Medicaid Type:
Insurance: Y N	Company Name:
	Policy#:
	Policy holder Name:

Please send us this completed form, a prescription for requested services, and any other documents that you feel may be helpful.