



# TheraCare Home Health

## TREATMENT ORDER

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**Patient Name Patient**

**Phone Number**

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**Diagnosis**

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**Patient Address**

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**Date of Birth**

**Social Security #**

**Medicare #**

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**Referring Physician**

**Physician Phone Number**

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**Services Ordered (Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Home Health Aide, Medical Social Worker)**

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**Physician Signature**

Please Print this Form, Complete it and Fax it to:

Texarkana area: (903) 794-4663  
Longview/Tyler area: (903) 758-4668  
Houston area: (281) 488-4662  
Dallas/Ft Worth area: (972) 434-9450  
Autsin area: (512) 459-3266