CHILDREN'S
Rehabilitation Service
Creating Partnerships ~ Building Futures

CHILDREN'S REHABILITATION SERVICE
MEDICAL/DENTAL PROVIDER INFORMATION FORM

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

CLIENT INFORMATION

SSN: ____-____-____

Last name: _____ First: _____ Middle: _____ Suffix: _____

CLIENT'S PRIMARY CARE PROVIDER INFORMATION

Name of client's family physician or pediatrician:

Last name: _____ First: _____

Name of clinic or practice: _____

Street: _____ City: _____

State: _____ ZIP code: _____-_____ Office phone: (_____) _____-_____

CLIENT'S DENTAL CARE PROVIDER INFORMATION

Name of client's family dentist or pediadontist:

Last name: _____ First: _____

Name of clinic or practice: _____

Street: _____ City: _____

State: _____ ZIP code: _____-_____ Office phone: (_____) _____-_____

CLIENT'S SPECIALTY CARE PROVIDER INFORMATION

If the client sees a medical specialist (not a CRS physician) with whom you would like CRS to coordinate the client's care, please complete below:

Provider's specialty:_____

Last name: _____ First: _____

Name of clinic or practice: _____

Street: _____ City: _____

State: _____ ZIP code: _____-_____ Office phone: (_____) _____-_____

CLIENT'S SPECIALTY CARE OR OTHER RELEVANT PROVIDER INFORMATION

If the client sees another medical specialist (not a CRS physician) or other health care provider with whom you would like CRS to coordinate the client's care, please complete below:

Provider's specialty: _____

Last name: _____ First: _____

Name of clinic or practice: _____

Street: _____ City: _____

State: _____ ZIP code: _____-_____ Office phone: (_____) _____-_____