ABC Pediatric Therapy Network

"Creating the best life for all children"

Physical Therapy Occupational Therapy Speech Therapy

FAX REFERRAL FORM / PRESCRIPTION

PATIENT NAME: ____ DATE OF BIRTH:_______________________

GUARDIAN'S NAME:____ HOME PHONE #_______________________

REASON FOR REFERRAL: _________Evaluate and Treatment ________PT________OT________Speech

REQUESTED BY: ____

PREFERRED LOCATION: _____WEST CHESTER _____WESTERN HILLS ______RED BANK ROAD

_____MIDDLETOWN _____MIAMISBURG ______BEAVERCREEK

DIAGNOSIS:

____ Anomia
____ Apraxia
____ Cerebral Palsy
____ CVA
____ Chondromalacia
____ Coordination Disorder
____ Encephalitis
____ Erb's Palsy
____ Fracture
____ Other: ____
____ Head Injury
____ Hemiplegia
____ High Risk Infant
____ Hydrocephalus
____ Hypertonicity
____ Hypotonicity
____ Improper Feeding
____ Joint Dislocation
____ JRA
____ Legg-Perthes
____ Mental Retardation
____ Muscular Dystrophy
____ Premature Birth
____ Spina Bifida
____ Spinal Cord Injury
____ Torticollis

ADDRESS DEFICITS IN:

____ Activities of Daily Living
____ Communication
____ Endurance
____ Fine Motor Skills
____ Functional Handwriting
____ Gross Motor Skills
____ Other:____
____ Oral Motor/Feeding Skills (**Height:**______ **Weight:**_________)
____ Perceptual Motor Skills
____ Range of Motion
____ Sensory Processing
____ Strength
____ Transfers

PRECAUTIONS:

____ Infectious Disease_____________________________________
____ Spinal Instability
____ Weight Bearing Restrictions_____________________________
____ Other:____

EQUIPMENT:

____ Ankle Foot Orthotics
____ Wheelchair Seating Recommendations
____ Assistive Device for Ambulation
____ Other____

***Please copy any past testing or referrals that have been made (MBS, GI, neurological work-up, nutritionist…)**

PHYSICIAN SIGNATURE:____DATE:_________________

PHYSICIAN NAME (print):____

PHYSICIAN PRACTICE:____

PRACTICE PHONE #:________________________________FAX #:______________________________________

For ABC purposes only: Request e-filed: ☐ Yes Initials:______________ Date:______________________

FAX REFERRAL TO:

WEST CHESTER 513-755-3762 WESTERN HILLS 513-922-1530 RED BANK ROAD 513-271-2425
MIDDLETOWN 513-755-3762 MIAMISBURG 937-281-1298 BEAVERCREEK: 937-427-9203