

**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 Treat [ ]  PT [ ]  OT [ ]  Speech

PREFERRED LOCATION: [ ]  West Chester [ ]  Western Hills [ ]  Red Bank [ ]  Middletown [ ]  Miamisburg [ ]  Beavercreek

MEDICAL DIAGNOSIS:

[ ]  No Known Medical Diagnosis, reason for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  ADD (F90.0)

[ ]  ADHD (F90.1)

[ ]  Angelman Syndrome (Q93.5)

[ ]  Apraxia (R48.2)

[ ]  Arthrogryposis (Q74.3)

[ ]  Asperger Syndrome (F84.5)

[ ]  Autism (F84.0)

[ ]  Cerebral Vascular Accident

[ ]  Central Auditory Processing Disorder (H93.25)

[ ]  Cerebral Palsy, Unspecified (G80.9)

[ ]  Chondromalacia (M94.2)

[ ]  Craniosynostosis (Q75.0)

[ ]  Disorder of CNS, Unspecified (G96.9)

[ ]  Down Syndrome (Q90.9)

[ ]  Ehler’s-Danos Syndrome (Q79.6)

[ ]  Encephalopathy (G93.4)

[ ]  Epilepsy, Unspecified (G40.9)

[ ]  Erb’s Palsy, Monoplegia (G83.23)

[ ]  Fracture

[ ]  Fragile X (Q99.2)

[ ]  Hemiplegia unspecified (G81.90)

[ ]  Hydrocephalus, Arnold Chiari Malformation (Q07.02)

[ ]  Hydrocephalus, Congenital, Unspecified (Q03.9)

[ ]  Feeding Difficulties (R63.3)

 **Height: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_**

[ ]  Juvenile Rheumatoid Arthritis

[ ]  Monoplegia (G83.23)

[ ]  Muscular Dystrophy (G71.0)

[ ]  Osteogenesis Imperfecta (Q78.0)

[ ]  Pervasive Developmental Disorder (F84.8)

[ ]  Premature Birth, Birth Injury-Unspecified (P15.9)

[ ]  Spina Bifida with Hydrocephalus, Unspecified (Q05.4)

[ ]  Spina Bifida without Hydrocephalus, Unspecified (Q05.5)

[ ]  Spinal Cord Injury

[ ]  Torticollis (M43.6)

[ ]  Traumatic Brain Injury

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRECAUTIONS:

[ ]  Infectious Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Spinal Instability

[ ]  Weight Bearing Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Seizure Disorder

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRAL FOR EQUIPMENT:

[ ]  Orthotics [ ]  Assistive Device for Ambulation

[ ]  Wheelchair Seating Recommendations [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Please attach any relevant testing results (MBS, GI, neurological work-up, nutritionist, etc.)**

PHYSICIAN SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN NAME (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN PRACTICE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRACTICE PHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_