****

**Physical Therapy Occupational Therapy Speech Therapy**

**FAX REFERRAL FORM / PRESCRIPTION**

**PATIENT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR REFERRAL:** [ ]  OT - Evaluate and Treat [ ]  PT - Evaluate and Treat [ ]  Speech Therapy - Evaluate and Treat

MEDICAL DIAGNOSIS:

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

[ ]  ADD (F90.0)

[ ]  ADHD (F90.1)

[ ]  Angelman Syndrome (Q93.51)

[ ]  Apraxia (R48.2)

[ ]  Arthrogryposis (Q74.3)

[ ]  Asperger Syndrome (F84.5)

[ ]  Autism (F84.0)

[ ]  Cerebral Infarction, Unspecified (I63.9)

[ ]  Central Auditory Processing Disorder (H93.25)

[ ]  Cerebral Palsy, Unspecified (G80.9)

[ ]  Chondromalacia (M94.20)

[ ]  Craniosynostosis (Q75.0)

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

[ ]  Down Syndrome (Q90.9)

[ ]  Ehler’s-Danos Syndrome, Unspecified (Q79.60)

[ ]  Encephalopathy, Unspecified (G93.40)

[ ]  Epilepsy, Unspecified (G40.9 series)

[ ]  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, Unspecified (G71.00)

[ ]  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 #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_