**A close up of a logo

Description automatically generated**

**Physical Therapy Occupational Therapy Speech Therapy**

**FAX REFERRAL FORM / PRESCRIPTION**

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

**Guardian**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_