

**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)

[ ]  Arnold-Chiari Syndrome without Spina Bifida or Hydrocephalus (Q07.00)

[ ]  Arnold-Chiari Syndrome with Spina Bifida (Q07.01)

[ ]  Arnold-Chiari Syndrome with hydrocephalus (Q07.02)

[ ]  Arnold-Chiari Syndrome with Spina Bifida or Hydrocephalus (Q07.00)

[ ]  Arthrogryposis (Q74.3)

[ ]  Asperger Syndrome (F84.5)

[ ]  Autism (F84.0)

[ ]  Central Auditory Processing Disorder (H93.25)

[ ]  Cerebral Palsy, Other (G80.8)

[ ]  Chondromalacia (M94.20)

[ ]  Craniosynostosis (Q75.0)

[ ]  Down Syndrome (Q90.9)

[ ]  Ehler’s-Danos Syndrome (Q79.6)

[ ]  Encephalopathy, Other (G93.49)

[ ]  Epilepsy, Other, not intractable, with status epilepticus (G40.801)

[ ]  Epilepsy, Other, not intractable, without status epilepticus (G40.802)

[ ]  Epilepsy, Other, intractable, with status epilepticus (G40.803)

[ ]  Epilepsy, Other, intractable, without status epilepticus (G40.804)

[ ]  Erb’s Palsy, Monoplegia (G83.23)

[ ]  Fracture

[ ]  Fragile X (Q99.2)

[ ]  Hemiplegia, Flaccid, unspecified side (G81.00)

[ ]  Hemiplegia, Spastic, unspecified side (G81.10)

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

Feeding disorder

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

 [ ]  R63.31 Pediatric feeding disorder, acute

 [ ]  R63.32 Pediatric feeding disorder, chronic

 [ ]  R63.39 Other feeding difficulties

[ ]  Juvenile Rheumatoid Arthritis

[ ]  Monoplegia (G83.23)

[ ]  Muscular Dystrophy, Duchenne or Becker (G71.01)

[ ]  Osteogenesis Imperfecta (Q78.0)

[ ]  Pervasive Developmental Disorder (F84.8)

[ ]  Spina Bifida – Thoracic with Hydrocephalus (Q05.1)

[ ]  Spina Bifida – Lumbar with Hydrocephalus (Q05.2)

[ ]  Spina Bifida – Cervical without Hydrocephalus (Q05.5)

[ ]  Spina Bifida – Thoracic without Hydrocephalus (Q05.6)

[ ]  Spina Bifida – Lumbar without Hydrocephalus (Q05.7)

[ ]  Spina Bifida – Sacral without Hydrocephalus (Q05.8)

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