FAX REFERRAL FORM / PRESCRIPTION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

REFERRAL: ☐OT - Evaluate and Treat ☐PT - Evaluate and Treat ☐Speech - Evaluate and Treat ☐Applied Behavioral Analysis (ABA)

MEDICAL DIAGNOSIS:

☐ No Known Medical Diagnosis, reason for referral: _____

☐ ADHD predominantly inattentive type (F90.0)
☐ ADHD, predominantly hyperactive type (F90.1)
☐ ADHD, combined type (F90.2)
☐ ADHD, other type (F90.8)
☐ ADHD, unspecified type (F90.9)
☐ Angelman Syndrome (Q93.51)
☐ Apraxia (R48.2)
☐ Asperger Syndrome (F84.5)
☐ Autism (F84.0)
☐ Cerebral Palsy, spastic qadriplegic (G80.0)
☐ Cerebral Palsy, spastic diplegic (G80.1)
☐ Cerebral Palsy, spastic hemiplegic (G80.2)
☐ Cerebral Palsy, athetoid (G80.3)
☐ Cerebral Palsy, ataxic (G80.4)
☐ Cerebral Palsy, other (G80.8)
☐ Cerebral Palsy, unspecified (G80.9)
☐ Childhood onset fluency disorder (F80.81)
☐ Cognitive communication deficit (R41.841)
☐ Down Syndrome (Q90.9)
☐ Dysphagia, oral phase (R13.11))
☐ Ehler's-Danlos Syndrome (Q79.6)

Feeding disorder
Height: _____ **Weight:** _____
- ☐ R63.31 Pediatric feeding disorder, acute
- ☐ R63.32 Pediatric feeding disorder, chronic
- ☐ R63.39 Other feeding difficulties

☐ Flat foot [pes planus] (acquired) right foot (M21.41)
☐ Flat foot [pes planus] (acquired) left foot (M21.42)
☐ Language disorder, phonological (F80.0)
☐ Language disorder, expressive (F80.1)
☐ Language disorder, mixed receptive-expressive (F80.2)
☐ Muscle weakness, generalized (M62.81)
☐ Muscle disorder, unspecified (M62.9)
☐ Other abnormalities of gait and mobility (R26.8)
☐ Other disorders of psychological development (F88)
☐ Other disturbances of skin sensation (R20.8)
☐ Other lack of coordination (R27.8)
☐ Other speech disturbances (R47.89)
☐ Other symbolic dysfunctions (R48.8)
☐ Slurred speech (R47.81)
☐ Social pragmatic communication disorder (F80.82)
☐ Specific developmental disorder of motor function (F82)
☐ Unspecified lack of coordination (R27.9)
☐ Other:

PRECAUTIONS:

☐ Infectious Disease: _____
☐ Spinal Instability
☐ Weight Bearing Restrictions: _____
☐ Allergy: _____
☐ Seizure Disorder
☐ Other: _____

REFERRAL FOR EQUIPMENT:

☐ Orthotics: _____
☐ Wheelchair Seating Recommendations
☐ Assistive Device for Ambulation
☐ 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 #: _____