Rehabilitation and Therapy

children's health®

Fax: 1 (877) 820-9077 **E-mail: rehabservices@childrens.com** **childrens.com/therapy**

Instructions: ***Items in RED must be completed to constitute a valid order.*** ***Items in BLUE must be completed to process your referral quickly.***

1. Complete form; 2. Copy Insurance Card; 3. Attach Demographic Form (Face Sheet); 4. Fax all information to 1-877-820-9077

If you have any questions, please call 1-877-820-9061.

***Patient Name:** _____ ***Date of Birth:** _____

Parent/Guardian Name: _____ ***Home Phone:** _____

Address (Street, Apt #, City, Zip): _____ ***Cell Phone:** _____

Preferred Language of Family: ☐ English ☐ Spanish ☐ Other: _____ ***Email:** _____

***Date Patient Last Seen by Physician:** _____ **Precautions:** _____

PHYSICAL THERAPY	OCCUPATIONAL THERAPY	SPEECH THERAPY
***ICD 10 DX:** _____	***ICD 10 DX:** _____	***ICD 10 DX:** _____
☐ Evaluation/Treatment ☐ **Aquatic Therapy	☐ Evaluation/Treatment ☐ **Aquatic Therapy	☐ Evaluation/Treatment
☐ Additional Info: _____	☐ Additional Info: _____	☐ Additional Info: _____

FEEDING EVALUATION AND THERAPY

***ICD 10 DX:** _____

EVALUATIONS:

☐ **Multidisciplinary Feeding Team Evaluation *(May include OT/ST/PSY/RD/GI)*

☐ Speech Therapist Feeding Evaluation

☐ **Video-fluoroscopic Swallow Study

TREATMENT:

☐ Speech Therapy

☐ Occupational Therapy

☐ Psychology

☐ Registered Dietitian

☐ **NMES *(Neuromuscular Electrical Stimulation)*

****TEAM ASSESSMENT**

***ICD 10 DX:** _____

☐ AUTISM TEAM ASSESSMENT *(Ages 3 and up; including OT and ST, and may include PT, RD and/or Psych Testing)*

☐ TRANSITIONAL SKILLS ASSESSMENT *(May include OT, PT and ST)*

☐ AUGMENTATIVE COMMUNICATION ASSESSMENT *(May include ST, OT and PT as appropriate)*

☐ NICU/NEWBORN DEVELOPMENTAL CLINIC *(May include PT/OT/ST and RD)*

****NEUROPSYCHOLOGY AND PSYCHOLOGY**

***ICD 10 DX:** _____

☐ Dallas – TBI, Seizure Disorders, stoke, encephalitis, CP

☐ Frisco – Developmental Delay, Learning Disability and Dyslexia, Suspected Mental Retardation, ADD/ADHD and Suspected Autism/Asperger's

****DAY PROGRAM**

***Intensive ICD 10 DX:** _____

☐ Evaluation / Treatment

☐ Additional Info: _____

☐ Day Neuro Treatment Program *(Including PT, OT, ST and NP)*

☐ Day Feeding Program *(Including ST, OT, Psych, RD)*

☐ Constraint Induced Movement Therapy *(OT)*

☐ Gait and Mobility Program *(PT)*

***Physician Name (please print):** _____ UPIN / NPI #: _____

Address: _____ Office Phone #: _____

City / State / Zip: _____ Fax #: _____

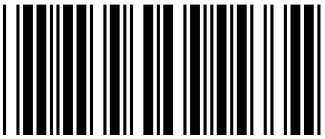
I hereby certify these services as medically necessary for the patient's plan of care.

***Physician Signature:** _____ ***Date:** _____ Time: _____

(Original Required – Stamp Not Acceptable)

LEGEND:
ADD = Attention Deficit Disorder
ADHD = Attention Deficit Hyperactivity Disorder
Dx = Diagnosis
Neuro = Neurological
OT = Occupational Therapy
Psych = Psychology;
PT = Physical Therapy
ST = Speech Therapy
RD= Registered Dietitian;
GI= Gasteroenterologist
NP= Neuropsychologist
**This service is not available at all locations

OUTPATIENT SERVICES PHYSICIAN PRESCRIPTION



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