Rehabilitation and Therapy

children's health

Location: Call Center -- Phone: 877-820-9061 Fax: 877-820-9077

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);

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

***ICD 10 DX:** _____

_____

Evaluation/Treatment

☐ Aquatic Therapy** ☐ Group Therapy

Additional Info: _____

OCCUPATIONAL THERAPY

***ICD 10 DX:** _____

_____

Evaluation/Treatment

☐ Aquatic Therapy** ☐ Group Therapy

Additional Info: _____

SPEECH LANGUAGE / FEEDING THERAPY

***ICD 10 DX:** _____

_____

Evaluation/Treatment

☐ Group Therapy
☐ NMES (*Neuromuscular Electrical Stimulation*)
☐ Video-Fluoroscopic Swallow Study (VFSS)**

Additional Info: _____

Multidisciplinary Feeding Team (OFA/IFE)**

***ICD 10 DX:** _____

_____

Evaluation/Treatment

Additional Info: _____

May Include:

Occupational Therapy
Psychology**
Gastroenterology
Speech Therapy
Registered Dietitians

REGISTERED DIETITIAN**

***ICD 10 DX:** _____

_____

Evaluation/Treatment

Additional Info: _____

*Dietitian services provided for patients receiving PT/OT/ST services.

PT & OT MOBILITY CLINIC

***ICD 10 DX:** _____

_____

Evaluation/Treatment

Special Equipment needs: _____

_____

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: _____

_____

☐ CITYVILLE – TBI, Seizure Disorders, stoke, encephalitis, CP
☐ PRESTON – Developmental Delay, Learning Disability and Dyslexia, Suspected Intellectual Disability, ADD/ADHD and Suspected Autism/Asperger's

DAY PROGRAM**

Intensive ICD 10 DX: _____

_____

Evaluation/Treatment

☐ Day Neuro Treatment Program *(Including PT, OT, ST and NP)*
☐ Day Feeding Program *(Including ST, OT, Psych, RD)*
☐ Constraint Induced Movement Therapy *(OT)*

***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

OUTPATIENTSERVICESPHYSICIANPRESCRIPTION

PHYO

children's health