Rehabilitation and Therapy

children'shealth®

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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