

Physician Referral for Occupational Therapy

Child's Name: _____	Date of Birth: _____
Parent's Name/s: _____	
Address: _____	

Phone Number/s: _____	
Email: _____	

Diagnosis (ICD-9): _____

- | | |
|---|---|
| <input type="checkbox"/> ICD 315.4 Dyspraxia Syndrome/ DCD | <input type="checkbox"/> ICD V41.8 Problems with Special Senses and Other Special Functions |
| <input type="checkbox"/> ICD 781.3 Coordination Disorder | <input type="checkbox"/> ICD 299.0 Autistic Disorder |
| <input type="checkbox"/> ICD 728.87 Muscle Weakness | <input type="checkbox"/> ICD 315.0 Developmental Learning Delay |
| <input type="checkbox"/> ICD 782.0 Sensory Defensiveness/ Disturbance of Skin Sensation | <input type="checkbox"/> ICD 315.9 Unspecified Delay in Development |
| <input type="checkbox"/> ICD 307.59 Other and Unspecified Disorders of Eating (Feeding Disorder of Infancy and Early childhood) | <input type="checkbox"/> ICD V40.0 Problems with Learning |
| <input type="checkbox"/> ICD 307.42 Persistent Disorder of Initiating or Maintaining Sleep | <input type="checkbox"/> ICD 314.0 Attention Deficit Disorder |
| <input type="checkbox"/> ICD 313.2 Sensitivity, Shyness, and Social Withdrawal Disorder | <input type="checkbox"/> ICD: _____ |

Medical History: Please list any information the therapist should know in treating this child (seizures, precautions, medication, allergies, and diagnosis):

Therapy Services Requested (Please check)

Evaluation

- Proceed with occupational therapy evaluation
- If desired, list specific evaluation measures requested: _____
- _____

Therapy

- Proceed with the appropriate occupational therapy as determined by the evaluation
- If desired, list specific therapeutic goals: _____
- _____

I verify that the services requested are medically necessary for the above named patient.

Physician's signature

Date

Address:

Phone #: