PHYSICIAN ORDERS/REFERRAL FORM

PATIENT INFORMATION

Patient Last Name	First Name	Date of Birth
Parent/Guardian Name	Phone #	Language ○ English ○ Spanish ○ Other ________
Address City	State	Zip
Medicaid #	Medicaid Provider	

ICD-9 DIAGNOSES

○ 299.00	Autism	○ 315.39	Other Speech / Language Disorder	○ 723.5	Torticollis
○ 307.0	Stuttering	○ 315.4	Developmental Coordination Disorder	○ 758.0	Down Syndrome
○ 314.00	ADD	○ 315.9	Unspecified Delay Development	○ 781.3	Lack of Coordination
○ 314.01	ADHD	○ 343.8	Cerebral Palsy	○ 783.42	Delayed Milestones
○ 315.2	Learning Disability	○ 389.00	Hearing Loss	○ 784.40	Voice Disturbance
○ 315.31	Expressive Language Disorder	○ 438.81	Apraxia	○ 787.2	Dysphagia
○ 315.32	Mixed Language Disorder	○ 719.7	Difficulty in walking	○ Other	____________________

Concerns: ____

PHYSICIAN INFORMATION

Name: ____

Address: ____

Phone: ____________________ Fax: ____________________ Group/Clinic Name: ______________________________

Referred By: ____

RECOMMENDED THERAPY

PHYSICAL THERAPY	OCCUPATIONAL THERAPY	SPEECH THERAPY
○ Evaluation only	○ Evaluation only	○ Evaluation only
○ Evaluation and Treatment	○ Evaluation and Treatment	○ Evaluation and Treatment
○ Freq:_____ x/wk	○ Freq:_____ x/wk	○ Freq:_____ x/wk

PHYSICIAN REFERRAL ONLY

Physician Signature: ____ Date: ______/______/________

(Confidential Information)

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