

Office Use Only:
MR identification label



Referral for Physical Therapy & Occupational Therapy

**Clinic/Physician Office Instructions: This form must be faxed as indicated below
If Demographics sheet is attached, fill in the Patient Name and Birthdate only
Please attach Medicaid referral. For insurance, complete the form below.**

Patient Name: _____ Birthdate: _____
Parent(s) : _____ Phone: _____

<input type="checkbox"/> Outpatient PT & OT Services <input type="checkbox"/> Serial Casting Clinic Services POSH schedulers: (205) 638-752 FAX: (205) 638-6740	<input type="checkbox"/> Seating Clinic Scheduling & Questions: (205) 638-9645 FAX: (205) 638-9459	<input type="checkbox"/> OT for CBIT Program for Tics & Tourette's Scheduling & Questions: (205) 638-6820 FAX: (205) 638-6063	<input type="checkbox"/> PT <input type="checkbox"/> OT Vestibular/Balance Disorders POSH schedulers: (205) 638-7527 FAX: (205) 638-6740
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Referring Physician: (please print) _____
 Referring Physician Address: _____ Office Phone: _____
 _____ FAX: _____

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Please note: Reason for referral, diagnosis and physician's signature are required from the physician's office prior to the patient being seen for either Physical Therapy and/or Occupational Therapy

Patient referred for:

<input type="checkbox"/> Occupational Therapy Evaluation & Tx	<input type="checkbox"/> Physical Therapy Evaluation & Tx
<input type="checkbox"/> Occupational Therapy Orthotics	<input type="checkbox"/> Physical Therapy Orthotics

Reason(s) for referral:

<input type="checkbox"/> Fine motor delay	<input type="checkbox"/> Difficulty walking/gait abnormality/toe walking
<input type="checkbox"/> Handwriting problems	<input type="checkbox"/> Gross motor delay
<input type="checkbox"/> Feeding difficulty	<input type="checkbox"/> Lack of coordination/balance
<input type="checkbox"/> Muscle weakness/Specify:	<input type="checkbox"/> Muscle weakness/Specify:
<input type="checkbox"/> Hand or upper extremity orthopedic problems	<input type="checkbox"/> Lower extremity orthopedic problems
<input type="checkbox"/> Torticollis	<input type="checkbox"/> Torticollis
<input type="checkbox"/> Sensory problems/sensory integration disorder	<input type="checkbox"/> Orthotics: Solid AFO, Hinged AFO, SMO, FO, Other:
<input type="checkbox"/> Pain in upper extremity/hand/Specify:	<input type="checkbox"/> Pain in lower extremity/Specify:
<input type="checkbox"/> Upper extremity serial casting, and orthotics as needed	<input type="checkbox"/> Lower extremity serial casting, cast shoes, knee immobilizers and orthotics as needed
<input type="checkbox"/> Splinting: specify:	<input type="checkbox"/> Mobility device: crutches, walker, canes
<input type="checkbox"/> Other: specify:	<input type="checkbox"/> Other: specify:

Diagnosis (please list ICD-10 code): _____

Scheduling urgency due to: post- surgical therapy needs post- BOTOX failure to thrive

Precautions (Concerns/contraindications): _____

Has child seen a therapist here before? Yes/Name: _____ No

Current Medications (list): _____

MRSA Positive? Yes No CMV active? Yes No

Type of Insurance: _____ Contract #: _____

Insurance authorization number: _____ (if Medicaid, please provide Medicaid referral)

Physician signature: _____ Date: _____ Time: _____