PHYSICIAN REFERRAL

Date: _____

Physical Therapy ☐ **Occupational Therapy** ☐ **Speech Therapy** ☐

New Referral ☐ **Annual Referral** ☐

Child's Name: _____ Date of Birth: _____

Parent/Guardian: _____

Address: _____

City: _____ _____ State: _____ Zip: _____

Phone Numbers: _____ (home) _____ (work) _____ (cell)

Reason for request for therapy:

*****PLEASE CHECK ALL CODES THAT APPLY TO THIS CHILD &/OR ADD OTHER CODES BELOW*****

- ☐ Lack of Coordination (R27.8)
- ☐ Down Syndrome (Q90.0)
- ☐ Abnormality of Gait (R26.0)
- ☐ Delayed Milestones (R62.0)
- ☐ Torticollis (Q68.0)
- ☐ Autistic disorder (F84.0)
- ☐ Lack of normal physiological development(R62.50)
- ☐ Cerebral Palsy – (G80.9)
- ☐ Mixed developmental disorder (F82.0)
- ☐ Expressive Language Delay (F80.1)
- ☐ Mixed Receptive-Expressive Lang. Disorder(F80.2)
- ☐ Abnormal posture (R29.3)
- ☐ Muscle weakness (M62.81)
- ☐ Congenital hemiplegia (G80.2)
- ☐ Spasm of muscle (M62.838)

OTHER (Specify diagnosis and ICD-10 Code): _____

I am in agreement with this request for Physical Therapy, Occupational Therapy, and/or Speech Therapy for this child.

Physician's Name: _____, MD UPIN #: _____

Phsyician's Signature: _____ Date: _____

Phone #: _____ Fax: _____