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| Patient Name:  | DOB:  |
| Parent/Guardian Name: | Phone Number:  |

**Reason for Referral:**

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| * Physical Therapy Evaluation & Treatment
* Occupational Therapy Evaluation & Treatment
* Speech Therapy Evaluation & Treatment
* Augmentative Alternative Communication Device Evaluation & Treatment
* Feeding Therapy Evaluation & Treatment: ❑ Occupational Therapy ❑ Speech Therapy ❑ Both
 |

**Diagnosis**:

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| \_\_ ADHD\_\_ Apraxia\_\_ Auditory Processing Disorder\_\_ Autism\_\_ Brachial Plexus Injury\_\_ Cerebral Palsy\_\_ Cochlear Implant\_\_ Communication Disorder\_\_ Cortical Visual Impairment (CVI)\_\_ CVA\_\_ Delayed Milestones\_\_ Down Syndrome\_\_ Expressive/Receptive Language | \_\_ Fluency Disorder\_\_ Fracture: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fragile X\_\_ Head Injury\_\_ Hearing Loss\_\_ Hemiplegia\_\_ Hypertonicity\_\_ Hypotonia\_\_ Dysphagia\_\_ Muscular Dystrophy\_\_ Neonatal Problems\_\_ OA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Orofacial Disorders/Anomalies | \_\_ Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharyngeal/Laryngeal Anomalies\_\_ Post-surgical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Premature Birth\_\_ Sensory Processing\_\_ Slurred Speech\_\_ Spina Bifida\_\_ Spinal Cord Injury\_\_ Strain/Sprain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Torticollis\_\_ Vocal Fold Pathology\_\_ Voice Disorders\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Impairments:**

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| \_\_ Balance/Fall Risk/Clumsy\_\_ Cognition\_\_ Coordination\_\_ Feeding and Swallowing | \_\_ Fine Motor Skills\_\_ Functional Handwriting\_\_ Gait\_\_ Motor Planning | \_\_ Strength/ROM\_\_ Visual Perceptual Skills\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Precautions:**

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| \_\_ NPO\_\_ Weight Bearing Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Physician Signature: |  Date: |
| Physician Name (print): |  |
| Physician NPI Number: |  |
| Practice Phone Number: |  Fax Number: |