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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: |