DT0185

Office Use Only:
MR identification label

Children's of Alabama

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) : _____ **Cell Phone:** _____ **Email:** _____

☐ Outpatient PT & OT Services ☐ Serial Casting Clinic Services **POSH schedulers:** **(205) 638-7527** **FAX: (205) 638-6740**	☐ Outpatient PT Intensive Therapy ☐ RAMP ☐ CIMT **POSH schedulers:** **(205) 638-7527** **FAX: (205) 638-6740**	☐ OT for CBIT Program for Tics & Tourette's **Scheduling & Questions:** **(205) 638-6820** **FAX: (205) 638-6063**	☐ PT ☐ OT Vestibular/Balance Disorders **POSH schedulers:** **(205) 638-7527** **FAX: (205) 638-6740**

Referring Physician: (please print) _____

Referring Physician Address: _____ **Office Phone:** _____

_____ **FAX:** _____

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:

☐ Occupational Therapy Evaluation & Treatment	☐ Physical Therapy Evaluation & Treatment
☐ Occupational Therapy Orthotics	☐ Physical Therapy Orthotics

Reason(s) for referral:

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

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