FAX TO:

304-229-7205

PT:_____

ID#_____

DOB:_____

PATIENT INFORMATION

Patient Name: DOB: Sex: (circle one) M F

Street: City: St.: Zip: .

Hm Ph# : Wk Ph# Cell# .

Parent/Guardian Full Name: Does this patient require home services? □ Yes □ No

INSURANCE INFORMATION

Primary Insurance: Provider# Grp/Policy# .

Policy Holder: SS# DOB: .

Secondary Insurance: Provider# Grp/Policy# .

Policy Holder: SS# DOB: .

Medicaid # SS# .

MCO# _____ .

TREATMENT INFORMATION

□ **EVALUATE AND TREAT:** .

TREATMENT DISCIPLINES: □ Occupational Therapy

□ Feeding/oral facilitation/dysphagia .

ICD-10/Diagnosis: □ Other:_____

□ F84.0 Autsim

□ F98.8 ADD

□ F90.9 ADHD

□ F81.9 Learning Disability

□ G80.9 Cerebral Palsy

□ Q90.9 Down Dyndrome

□ F80.9 Developmental Delay

□ F82 Dev. Coordination Disorder

□ R26.2 Difficulty Walking

□ R26.89 Abnormality of Gait

□ R48.2 Apraxia

□ R27.8 Lack of Coordination

□ M43.6 Torticollis

□ R13.10 Dysphagia

□ R63.3 Difficulty Feeding

PRACTICE INFORMATION

Ordering Physician: Practice Name: .

Address: Fx# Ph# .

Comments: .

I certify that this patient is under my care. The rehabilitation services prescribed by me are medically necessary & in accordance with a plan established & periodically reviewed by me.

Physician Name (printed): Date: .

Physician Signature: .