



FAX TO:
205-660-6331

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: _____

- | | | |
|--|---|---|
| <input type="checkbox"/> F84.0 Autism | <input type="checkbox"/> Q90.9 Down Syndrome | <input type="checkbox"/> R48.2 Apraxia |
| <input type="checkbox"/> F98.8 ADD | <input type="checkbox"/> F80.9 Developmental Delay | <input type="checkbox"/> R27.8 Lack of Coordination |
| <input type="checkbox"/> F90.9 ADHD | <input type="checkbox"/> F82 Dev. Coordination Disorder | <input type="checkbox"/> M43.6 Torticollis |
| <input type="checkbox"/> F81.9 Learning Disability | <input type="checkbox"/> R26.2 Difficulty Walking | <input type="checkbox"/> R13.10 Dysphagia |
| <input type="checkbox"/> G80.9 Cerebral Palsy | <input type="checkbox"/> R26.89 Abnormality of Gait | <input type="checkbox"/> 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: _____