Outpatient Rehabilitation Services Referral Request Form
Occupational, Physical & Speech Therapy

Scheduling Line: 714.509.4220 **Fax: 714.509.8456**

Thank you for referring your patient to CHOC Children's Rehabilitation Department. To better serve you and your patient, please provide us with the following information by fax.

- ☐ **This COMPLETED Form**
- ☐ **Copy of Insurance Card**
- ☐ **Legible medical records supporting the reason for the referral and diagnosis including any radiology findings pertinent to referral (ie: MBSS, CT Scan, MRI)**
- ☐ **ICD-10 codes for referring diagnosis and chief complaint**
- ☐ **Insurance Authorization including CPT codes authorized for the requested referral**

Patient Information

Does the patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship_________________

Patient Name: ______________________________ Date of Birth: ________ / _______ / __________

Parent/Guardian: ______________________________ Parent Phone: ______________________________

Insurance: ______________________________ Parent Cell: ______________________________

Please indicate the services you are requesting:

- ☐ **Developmental Occupational Therapy**
- ☐ **Developmental Speech Therapy**
- ☐ **Hand Therapy**
- ☐ **Ortho/Sports Medicine Physical Therapy**
- ☐ **Serial Casting**
- ☐ **Other: ________________________________**
- ☐ **Developmental Physical Therapy**
- ☐ **OT/ST Feeding Therapy**
- ☐ **Wound Care**
- ☐ **Concussion (specify OT/PT/ST)**
- ☐ **Vocal Cord Dysfunction**

ICD 10/Chief Complaint: ____

Is this an emergent referral? Yes/No

If yes, please explain: ____

Referring Provider Name: ________________________________ Phone: _______________ Fax:______________

Provider Address:______________________________________ City: _________________ Zip: _____________

Provider Signature: ________________________________ Date: _____________ Time: __________

Updated 11.16.2015