**Shape, arrow

Description automatically generatedStarfish Youth Therapy Center**

**A PROGRAM OF WATERFALL CLINIC**

**ABA Therapy Occupational Therapy Speech Therapy Child Psychiatry**

**CLIENT FAX REFERRAL FORM**

**REFERRAL DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: M  F

GUARDIAN NAME(S): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR REFERRAL:**  OT - Evaluate and Treat  ABA Therapy - Evaluate and Treat  Speech Therapy - Evaluate and Treat

Dr. Davies Child Psychiatrist

**REFERRAL COMMENTS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL DIAGNOSIS**:

**\*MEDICAL DIAGNOSIS OF AUTISM REQUIRED FOR ABA, OT or SPEECH SERVICES\***

**\*INCLUDE DOCUMENTATION OF AUTISM DIAGNOSIS IN FAXED REPORT\***

ADD (F90.0)

ADHD (F90.1)

Angelman Syndrome (Q93.51)

Apraxia (R48.2)

Asperger Syndrome (F84.5)

Autism (F84.0)

Cerebral Infarction, Unspecified (I63.9)

Central Auditory Processing Disorder (H93.25)

Cerebral Palsy, Unspecified (G80.9)

Craniosynostosis (Q75.0)

Delayed Milestone in Childhood (R62.0)

Developmental Disorder of Speech and Language, Unspecified

(F80.9)

Disorder of CNS, Unspecified (G96.9)

Down Syndrome (Q90.9)

Dysphagia, Unspecified (R13.10)

Ehler’s-Danos Syndrome, Unspecified (Q79.60)

Encephalopathy, Unspecified (G93.40)

Epilepsy, Unspecified (G40.9 series)

Erb’s Palsy, Monoplegia (G83.23)

Fragile X (Q99.2)

Generalized Weakness (M62.81)

Hemiplegia unspecified (G81.90)

Hydrocephalus, Congenital, Unspecified (Q03.9)

Feeding Difficulties (R63.3)

**Height: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_**

Juvenile Rheumatoid Arthritis

Monoplegia (G83.23)

Muscular Dystrophy, Unspecified (G71.00)

Osteogenesis Imperfecta (Q78.0)

Other Disorders of the Nervous System (G98.8)

Other Lack of Coordination (R27.8)

Pervasive Developmental Disorder (F84.8)

Specific Developmental Disorder of Motor Function

(F82)

Spina Bifida with Hydrocephalus, Unspecified (Q05.4)

Spina Bifida without Hydrocephalus, Unspecified (Q05.5)

Spinal Cord Injury

Traumatic Brain Injury

Mental Health Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRECAUTIONS:**

Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE: \*Copy of insurance card can be obtained at time of service.**

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN NAME (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN PRACTICE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRACTICE PHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_