**Starfish 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 #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_