Phoenix Children's

OCCUPATIONAL THERAPY REFERRAL/ORDER

Name: _____
MRN: _____
DOB: _____
or Apply Patient Label

REFERRAL

Please complete the following information as it applies to your referral.

Patient Name: _____ DOB: _____
Parent/Guardian: _____ Phone #_____
MR # *(for internal referral)* _____

Date of Onset (mm/dd/yyyy) _____ Routine ☐ STAT ☐

DIAGNOSIS: ICD-10 CODE(S): ***Please check all that apply to this child.***

	ICD-10		ICD-10
☐ Autism	F84.0	☐ Lack of Normal Physiological Development	R62.50
☐ Unspecified Delay in Development	R62.59	☐ FTT	R62.51
☐ Unspecified Disorders of the Nervous System	G98.8	☐ Delayed Milestones	R62.0
☐ Hypotonia	P94.2	☐ TBI	S06.9X0S
☐ Brachial Plexus Injury <1	P14.3	☐ _____ Hemiparesis	
☐ Brachial Plexus Injury >1	G54.0	☐ Other (include code(s)_____	
☐ Lack of Coordination	R27.9		

Please check ALL treatments that are related to this child.

TREATMENT PLAN: **PROCEDURE CODE:**

Frequency and Duration: _____

☐ Evaluation	97165, 97166, 97167
☐ Re-Evaluation	97168
☐ Therapeutic Exercise	97110
☐ Therapeutic Activities	97530
☐ Joint Mob/Manual Therapy	97140
☐ Neuro-muscular Re-Ed	97112
☐ Activities of Daily Living	97535
☐ Cognitive Skills	97532
☐ Orthotic/Splint Fitting & Training	97760
☐ E-stim attended	97032
☐ Splinting fabrication and training	97760
☐ Other (*List in order of importance)* _____ _____ _____ _____	

_____ _____
PRACTITIONER'S NAME *(PLEASE PRINT)* PHONE NUMBER

_____ _____
ADDRESS FAX NUMBER

_____ _____ _____
PRACTITIONER'S SIGNATURE DATE TIME

Non-Phoenix Children's Physicians, please provide authorization for therapy service ordered.

Insurance: _____

Insurance ID#_____ Group # _____

Authorization #_____ # of visits: _____

Auth. Valid From: _____ Expires: _____

Thank you for your referral and for your assistance in the continuing care of your patient
1919 East Thomas Road, Phoenix, AZ 85016-7710 Phone: 602-933-0980 Fax: 602-933-2465 email: OPRehabScripts@phoenixchildrens.com