



PHYSICAL 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 codes and checkboxes for various conditions like Lack of Normal Physiological Dev, Delayed Milestones, Hypotonia, etc.

Please check ALL treatments that are related to this child:

TREATMENT PLAN:

PROCEDURE CODE:

Frequency & Duration:

- Checkboxes for treatments like Evaluation, Re-Evaluation, Tx-ROM, Strengthening, Endurance Training, etc.

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

