Starfish Youth Therapy Center

A PROGRAM OF WATERFALL CLINIC

ABA Therapy Occupational Therapy Speech Therapy

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

REFERRAL COMMENTS: _____

_____

MEDICAL DIAGNOSIS:

MEDICAL DIAGNOSIS OF AUTISM REQUIRED FOR REFERRAL

☐ 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
☐ 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 #:_____

FAX REFERRAL TO:

STARFISH YOUTH THERAPY CENTER: 541.756.6234. 465 ELROD AVE. SUITE 101. COOS BAY, OR 97420