REFERRAL/ORDER FORM REHABILITATION SERVICES

All Services available in Hartford, Farmington, Glastonbury; unless otherwise noted. Aquatic Therapy available in Avon.

Connecticut Children's Patient Label
for internal use only

Patient Name: (Last) ______________________ (First) ______________________

Street Address: ______________________

City/State/Zip: ______________________ **Date of Birth:** ______________________

Preferred Phone: (Home) ____________ (Work) ____________ (Cell) ____________

Parent/Guardian/DCF: ______________________ **Preferred Language:** ______________________

If DCF: (Social Worker name) ______________________ (Phone) ______________________

This visit is: ☐ Routine ☐ Semi-urgent (within 2 weeks) **Urgent: Please call Department for urgent appointments.**

Insurance:______________________ **ID#** ______________________

SERVICES REQUESTED (PLEASE CHECK ALL THE APPLY) *Please specify history/symptoms/special needs for the services below:*

☐ **Audiology**
Phone 860.545.9642 • Fax 860.545.9662
☐ *Evaluation and Treatment* ☐ *Vestibular and Balance*

History/symptoms/special needs: ______________________

☐ **Speech-Language Pathology**
Phone 860.837.5916 • Fax 860.545.8077
☐ *Evaluation and Treatment*
☐ *Flexible Endoscopic Evaluation of Swallow (FEES) - Eval. and Treat*
☐ *Modified Barium Swallow (MBS/VFSS) - Eval. and Treat*
☐ *Passy-Muir Valve (PMV) - Eval. and Treat*
☐ *Other:* ______________________

History/symptoms/special needs: ______________________

For referrals to the Autism Spectrum Assessment Program (ASAP) please refer to the guidelines posted on the Connecticut Children's website

ICD-10 codes are required for the services below:

☐ **Occupational Therapy**
Phone 860.837.6300 • Fax 860.545.8077
☐ *Evaluation and Treatment* ☐ *Biofeedback* ☐ *Tone Management*
☐ *Aquatic Therapy* ☐ *Splinting*

Diagnosis (ICD-10 code(s) required): ______________________

Description: ______________________

☐ **Feeding Team (Hartford only)**
Phone 860.545.9889 • Fax 860.545.8605
☐ *Evaluation*

(Includes OT,SLP, Nutrition and/or Psychology)

Diagnosis (ICD-10 code(s) required): ______________________

Description: ______________________

☐ **Physical Therapy**
Phone 860.837.6300 • Fax 860.545.8077
☐ *Evaluation and Treatment* ☐ *Biofeedback* ☐ *Adaptive Equipment*
☐ *Aquatic Therapy* ☐ *Other:* ______________________

Diagnosis (ICD-10 code(s) required): ______________________

Description: ______________________

☐ **Sports Physical Therapy**
Phone 860.837.9246 • Fax 860.837.9341
☐ *Evaluation and Treatment*

Diagnosis (ICD-10 code(s) required): ______________________

Description: ______________________

REASON FOR REFERRAL/BACKGROUND

____

Precautions ____________ *Contraindications* ____________ *Frequency of treatment* ________ *Duration of treatment* ________

REFERRING PROVIDER INFORMATION

Referring Provider: ______________________

Referring Provider: (Phone) ______________________ (Fax) ______________________

Patient's Primary Care Physician (if different from referring)**:** ______________________

Is the family aware of the reason for referral? ☐ Yes ☐ No

______________________ Date ________ Time ______
Signature/Credentials of ordering Practitioner (APRN, PA, Non-resident MD or DO)

connecticutchildrens.org
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