Connecticut Children's

Date of order: _____

Clinical Services Order Form

Fax: 860-837-9898 or 860-545-9502

Patient Name: (Last)_____(First)_____ DOB:_____

Address:_____ City/State/Zip:_____

Sex (Legal): ☐M ☐ F Gender Identity: ☐M ☐ F ☐ Other _____ Needs Interpreter? ☐ Y ☐ N Language:_____

This visit is: Routine *Please call 833-733-7669 for all urgent requests*

Audiology ICD 10 code:_____ (required)

☐ Evaluation & Treatment ☐ Vestibular & Balance ☐ Sedated BAER ☐ Other

Reason for referral:_____

Contraindications/precautions/history:_____

Feeding Team ICD 10 code:_____ (required)

(Ordering provider acknowledges they are ordering multiple services including Occupational Therapy, Nutrition & Speech Therapy)

☐ Evaluation ☐ Other

Reason for referral:_____ Allergies:_____

Contraindications/precautions/history:_____

Nutrition ICD 10 code:_____ (required)

☐Evaluation & Treatment ☐ Other

Reason for referral:_____Allergies:_____

Contraindications/precautions/history:_____

Occupational Therapy ICD 10 code:_____ (required)

☐Evaluation & Treatment ☐Aquatic Therapy ☐Biofeedback ☐Feeding ☐Modalities ☐Splinting ☐ Other

Reason for referral:_____

Contraindications/precautions/history:_____

Physical Therapy ICD code: _____ (required)

☐Evaluation & treatment ☐Adaptive equipment ☐Aquatic therapy ☐Biofeedback ☐Pelvic floor ☐Schroth ☐Other

Reason for referral:_____

Contraindications/precautions/history:_____

Speech-Language Pathology

☐Evaluation & Treatment ☐Clinical swallow eval & treat ☐Flexible endoscopic eval of swallow ☐Passy-Muir Valve

☐Modified barium swallow/video fluoroscopic swallow study *please also order Fluoroscopy under Radiology ☐Other

Reason for referral:_____

Contraindications/precautions/history:_____

Radiology *Modalities: Flouroscopy/X-ray/CT/Ultrasound/MRI*

Expected date of exam:_____ Examination required:_____

Reason for exam/relevant history:_____

Is sedation required? ☐ Yes ☐ No Please note: Short history & Physical Form required to schedule sedation

Referring provider:_____Phone:_____ Fax:_____

Primary Care provider: (if different from referring)_____ Is family aware of this referral? ☐ Yes ☐ No

Signature/Credentials of provider:_____ Date:_____