Development is CHILD'S PLAY!

Where Fun and Function Go Hand-in-Hand

Referral for Occupational Therapy

✓ Child's name: _____ √ Date of Birth: _____

✓ Occupational therapy for 60 minutes ___ once a week ___ twice a week

✓ Diagnosis/diagnoses: ***If more than one diagnosis is used please indicate primary with an ***

ICD-10		
	F41….	Anxiety, Unspecified **specify type/code:**
	F51.01	Primary Insomnia, initiating or maintaining sleep
	F50.9	Eating Disorder, Unspecified
	F82.0	Specific Developmental Disorder of Motor Function
	F84….	Autistic Disorder **specify type/code:**
	F90….	ADHD **specify type/code:**
	F91.3	Oppositional Defiant Disorder
	F93.9	Childhood Emotional Disorder
	G70.2	Congenital and/or Developmental Myasthenia
	G80….	Cerebral Palsy **specify type/code:**
	G96.9	Disorder of the Nervous System, Unspecified
	M62.81	Muscle Weakness (Generalized)
	Q90.9	Down Syndrome, Unspecified
	Q99.2	Fragile X Syndrome
	R27.0	Ataxia, Unspecified
	R29.3	Abnormal Posture
	R62.0	Delayed Milestone in Childhood
	R63.3	Feeding Difficulties, Oral Aversion
		Other:

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√ Physician identifying information:

√ Physician License/NPI #:

I verify that the services requested are medically necessary for the above-named patient.

√ Date: _____ √ Signature: _____

Please mail this form to the address below or fax to (408) 996-0679

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