Development is CHILD'S PLAY!
Where Fun and Function Go Hand-in-Hand

Referral for Occupational Therapy

Dear Physician:

Your patient _____ is seeking occupational therapy services with us.

Although occupational therapists outside of a hospital are not required to work under a physician's referral, insurance companies often **require** documentation of a physician's referral for consideration of reimbursement. In order to facilitate processing of insurance claims, a physician's referral with diagnosis is highly recommended.

In the absence of other diagnoses, the following may best describe the difficulties experienced by many of the children seen in our clinic:

M62.81 Muscle Weakness (Generalized)
G70.2 Congenital and/or Developmental Myasthenia or
F82 Specific Developmental Disorder of Motor Function

If the child has adequate coordination but has suspected sensory issues, some physicians use the diagnosis
F93.9 Childhood Emotional Disorder, Unspecified or
G96.9 Disorder of Central Nervous System, unspecified

Given a release of information, we would be happy to speak with you if there are questions about a diagnosis or our services.

Please fill out the attached, **accompanying form** and mail it to the address below, fax to (408) 996-0679 or scan and email to otdicp@gmail.com.

Thank you for your support of this child and family.

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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 ***

___ M 62.81 Muscle Weakness (Generalized)

___ G70.2 Congenital and/or Developmental Myasthenia

___ F82 Specific Developmental Disorder of Motor Function

___ R29.3 Abnormal Posture, Head Position

___ G80.__ Cerebral Palsy; **specify type**: _____

___ G96.9 Disorder of Nervous System, Unspecified

___ R63.3 Feeding Difficulties, Oral Aversion

___ F50.9 Eating Disorder, Unspecified

___ F51.01 Primary Insomnia, Difficulty Initiating or Maintaining Sleep

___ F84.0 Autistic Disorder; ___F84.2 Rett Syndrome; ___F84.5 Asperger's Syndrome;
___F84.9 Pervasive Developmental Disorder, Unspecified

___ Q99.2 Fragile X Syndrome

___ Q90.9 Down Syndrome, Unspecified

___ F 90.1 ADHD, Predominantly Hyperactive Type; ___ F90.2 ADHD, Combined Type;
___ F90.0 ADHD, Predominantly Inattentive Type; ___ F90.9 ADHD, Unspecified Type

___ F41.1 Generalized Anxiety Disorder; ___ F41.9 Anxiety, Unspecified;
___ F40.8 Other Phobic Anxiety Disorders

___ F93.9 Childhood Emotional Disorder, Unspecified

___ Other: _____ (specify)

✓ Physician name, address, and <u>license</u> number:

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

✓ Signature: _____ ✓ Date: _____

✓ NPI # _____

Please mail this form to the address below, fax to (408) 996-0679, or email to otdicp@gmail.com. Thank you!