Pediatric Rehabilitation Prescription/Referral Form

Date of Referral:_____ OSF MR#: (if known) _____
***Patient Name:**_____**DOB:**_____
***Parent/Caregiver:**_____
***Address:**_____
_____
***Phone: (home)**_____(work)_____(cell)_____(message)_____

***Medical Diagnosis (please write ICD9 Code(s):**_____
_____
_____

Treating Diagnosis:_____

Infectious Diseases:_____

- ☐ Speech/language evaluation
- ☐ Speech/language treatment
- ☐ Oral motor/feeding evaluation
- ☐ Oral motor/feeding treatment
- ☐ Video Fluoroscopic Swallow Study (VFSS)
- ☐ Aural Rehab evaluation
- ☐ Aural Rehab therapy
- ☐ Occupational therapy evaluation
- ☐ Occupational therapy treatment
- ☐ Physical therapy evaluation
- ☐ Physical therapy treatment
- ☐ Splint evaluation and fabrication for _____
- ☐ Other_____

Reason for Referral:

***Billing Source:**

_____ _____/_____
***Physician Signature** ***Physician Name – Printed/Physician NPI#**

_____ _____
***Time/Date Physician Signed** ***Office Phone Number/Fax Number/Contact Person**

***REQUIRED FOR SERVICE**
Patients with HUMANA QCP OR TRICARE CAN NOT BE SEEN without pre-authorization. If pre-authorization of insurance is required, has this been done? ◯Yes ◯No
Authorization #_____ **Number of visits approved**_____

If immediate attention is required please call 309-655-6961. Fax form to Pediatric Developmental Rehabilitation – 309-655-6472, and **mail original** to Peds Rehab, 530 NE Glen Oak, Peoria, IL 61637. This referral page will serve as the prescription for service when physician signature present.

For Peds Rehab Office: Appointment scheduled on _____ at _____. Faxed to referring physician's office on _____. Initials_____