



# REFERRAL INTAKE FORM

Please fax your Referral Form to Riverkids at:

**Houston Area** Fax: 1-888-449-0039, or call us at 281-692-9559

**Austin Area** Fax: 1-888-291-1132, or call us at 512-431-4721

### DATE OF INTAKE:

**DISCIPLINE NEEDED:**  PHYSICAL THERAPY  SPEECH THERAPY  OCCUPATIONAL THERAPY

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Guardian Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Can we TEXT you?:  Yes  No

Email Address: \_\_\_\_\_

Primary Language:  English  Spanish  Other: \_\_\_\_\_

Patient Availability:  All Day  Mornings  Afternoons  After School  Other: \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_ Medicaid / Patient ID #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Medicaid / Patient ID #: \_\_\_\_\_

### REFERRAL / PHYSICIAN INFORMATION

Ordering Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### TREATMENT INFORMATION

**ICD-9 / Diagnosis:**  Other \_\_\_\_\_ ICD-9: \_\_\_\_\_ Dx: \_\_\_\_\_

<input type="checkbox"/> 194.0 Neuroblastoma	<input type="checkbox"/> 315.9 Developmental Delay	<input type="checkbox"/> 742.1 Microcephally
<input type="checkbox"/> 277.87 Mitochondrial Disease	<input type="checkbox"/> 319 MR	<input type="checkbox"/> 758.0 Down's Syndrome
<input type="checkbox"/> 299.00 Autism	<input type="checkbox"/> 320.09 Bacterial Meningitis	<input type="checkbox"/> 765.20 Prematurity
<input type="checkbox"/> 299.90 PDD NOS	<input type="checkbox"/> 343.90 Cerebral Palsy	<input type="checkbox"/> 767.8 Torticollis
<input type="checkbox"/> 787.20 Dysphagia	<input type="checkbox"/> 348.30 Encephalopathy	<input type="checkbox"/> 780.39 Seizures NOS
<input type="checkbox"/> 315.31 Expressive Language Delay	<input type="checkbox"/> 359.1 Muscular Dystrophy	<input type="checkbox"/> 781.20 Abnormality of Gait
<input type="checkbox"/> 315.32 Language Delay	<input type="checkbox"/> 438.81 Apraxia of Speech	<input type="checkbox"/> 784.69 Apraxia of Non Speech
<input type="checkbox"/> 315.39 Speech Delay	<input type="checkbox"/> 741.00 Spina Bifida	

### MEDICATIONS:

**OTHER SERVICES CURRENTLY PROVIDED?** \_\_\_\_\_ **REFERRED BY:** \_\_\_\_\_

**OTHER HOME HEALTH SERVICES IN THE PAST?** \_\_\_\_\_ **PERSON COMPLETING INTAKE:** \_\_\_\_\_

**HOMEBOUND STATUS:**  Unable to leave the home  Single parent caretaker  Multiple children with needs

Requires assistive device  Taxing effort to leave home  Transportation  Medically fragile  Funding

Other \_\_\_\_\_

### COMMENTS:

\*\*\*FOR PHYSICIAN'S ORDERS OTHER THAN PRESCRIBED ON THE 485 PLAN OF CARE:

**PHYSICIAN'S NAME:** \_\_\_\_\_

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_