WVU Medicine Children's
NEURODEVELOPMENTAL CENTER

Pediatric Rehabilitation Services Referral

PHONE: **304-598-4300** FAX: **304-598-4677** **201 Baker's Ridge Rd Morgantown, WV 26506**

Date of Referral: ______/______/______

Referring Physician: ______________________ Contact Person: ______________________

Phone #: ______________________ Fax #: ______________________

Reason for Referral: ____

PATIENT INFORMATION

Name: (Last) ______________________ (First) ______________________ (MI) ______

DOB: ______/______/______ Social Security #: ______________________

Address: ____

Diagnosis ICD- 10: ____

Parent/Guardian: ______________________ Phone #: ______________________

INSURANCE INFORMATION

Insurance Co. Name: ____

Policy ID #: ______________________ Subscriber's Name: ______________________

REQUESTING SERVICE

☐ **Physical Therapy Evaluation & Treatment**

Indications for care, check all that apply:

- ☐ **Balance impairment**
- ☐ **Coordination impairment**
- ☐ **Developmental impairment**
- ☐ **Endurance impairment**
- ☐ **Mobility impairment**
- ☐ **Sensory/perceptual impairment**
- ☐ **Weakness**
- ☐ **Other:** ____________

☐ **Occupational Therapy Evaluation & Treatment**

Indications for care, check all that apply:

- ☐ **Strengthening**
- ☐ **Increasing ROM**
- ☐ **Improving coordination**
- ☐ **Building endurance**
- ☐ **Improving balance**
- ☐ **Splinting for support**
- ☐ **Splinting for function**
- ☐ **Improving for accommodating sensory limitations**
- ☐ **Improving or adapting to perceptual dysfunction**
- ☐ **Other:** ____________

☐ **Speech Therapy Evaluation & Treatment**

Indications for care, check all that apply:

- ☐ **Speech and language evaluation and treatment**
- ☐ **Swallow therapy evaluation and treatment**
- ☐ **Voice therapy evaluation and treatment**