NYU Langone Health

RUSK REHABILITATION

REFERRAL FOR OUTPATIENT **PEDIATRIC OCCUPATIONAL THERAPY**

FAX to RUSK REHABILITATION • 212.263.4555

Date:_____
Patient Name: _____ Sex: M □ F □
Patient Date of Birth:_____
Caregiver's Name: _____
Telephone Number: Contact 1: (_____) _____ - _____
Contact 2: (_____) _____ - _____
Patient Address: _____
_____
Primary Insurance:_____ Policy Number:_____ Insured Name:_____
Secondary Insurance:_____ Policy Number:_____ Insured Name:_____

Medical Diagnosis: _____ **ICD 10:**_____

_____ Cerebral Palsy
_____ Developmental Delays
_____ Spinal Cord Injury
_____ Sensory Processing Disorder/PDD/Autism
_____ Muscular Dystrophy
_____Orthopedic/Sports Injuries
_____ CVA
_____ Brachial Plexus
_____ Torticollis
_____ Traumatic Brian Injury/ Concussion
_____ Other_____

Onset Date: _____

Prescription for: (Please select)

_____ ADL Training
_____ Pool Therapy
_____ Therapeutic Exercise
_____ Neuro Re-Ed
_____ Orthotic Eval and Fabrication
_____ W/C Evaluation
_____ Therapeutic Activity
_____ Community Reintegration
_____ Sensory Integration
_____ Assistive Technology
_____ W/C Follow-up
_____Modalities (ie. FES, E-stim,ect)
_____ CIT
_____Vision/Concussion
_____Other_____
_____ OT Pediatric Eval

Physician Order Frequency and Duration: _____ (Times/week) _____ (numbers of months)

Physician's Name (Please Print): _____
License Number: _____ UPIN: _____ NPI# _____
Office Telephone: _____Office Fax: _____
Physician's Signature: _____

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