SMALL HANDS BIG HEARTS
PEDIATRIC THERAPY MANAGEMENT LLC
a Merakey company

Fax your referral to our central Intake at:
(682) 738-3272

***All information must be completed before referral can be processed for evaluation.** Today's Date: ____________

PATIENT INFORMATION

Patient Name: Age: DOB: Sex: M F
Street Address: City: Zip:
Home Phone: Work Phone:
Parent Full Name: Time Available for Therapy:
Parent Email: Dominant Language: ☐ English ☐ Spanish ☐ Other:
Parent Concerns:

INSURANCE INFORMATION

Primary Carrier Name: Provider #: Group/Policy #:
Insured Name: Social Security #: DOB:
Secondary Carrier Name: Provider #: Group/Policy #:
Insured Name: Social Security #: DOB:
Medicaid #:

TREATMENT INFORMATION

☐ **EVALUATION ONLY** ☐ **EVALUATE AND TREAT:**

TREATMENT DISCIPLINES:
☐ Feeding/Oral Facilitation/Dysphagia
☐ Occupational Therapy
☐ Physical Therapy
☐ Speech Therapy

ICD-10/DIAGNOSIS:

☐ F90.0 ADHD predominantly inattentive type
☐ F90.1 ADHD predominantly hyperactive type
☐ F84.0 Autistic Disorder
☐ F91.9 Conduct Disorder, unspecified
☐ G80.0 Spastic Quadriplegic Cerebral Palsy
☐ G80.9 Cerebral Palsy, Unspecified
☐ R48.1 Agnosia
☐ R48.2 Apraxia
☐ R62.0 Delayed milestone in childhood
☐ F82 Specified Disorder of Motor Function
☐ F81.9 Disorders of Scholastic Skills, unspecified
☐ F89 Disorder of Psychological Development

☐ R62.50 Unspec lack of expected physiological develop.
☐ F80.1 Expressive Language Disorder
☐ R26.2 Difficulty in walking
☐ Q90.9 Down's Syndrome, unspecified
☐ R26.0 Ataxic gait
☐ R26.1 Paralytic gait
☐ R26.89 Other abnormalities of gait & mobility
☐ R26.9 Unspec abnormalities of gait & mobility
☐ R27.0 Apaxia, unspecified
☐ R27.8 Other lack of coordination
☐ R27.9 Unspecified lack of coordination
☐ Q02 Microcephaly

☐ F80.2 Mixed Receptive-Expressive Language Dis.
☐ F84.9 Pervasive Developmental Disorder
☐ F80.0 Phonological disorder
☐ F80.89 Other Disorders Speech and Language
☐ R47.02 Dysphasia
☐ R47.81 Slurred Speech
☐ R47.89 Other Speech Disturbances
☐ Q05.4 Unspec Spina Bifida w/ Hydrocephalus
☐ M43.6 Torticollis
☐ ____________
☐ ____________

PRACTICE INFORMATION

Ordering Physician/Practitioner: Practice Name:
Address: Fax: Phone:
Referred By: Referral Phone:
Comments:

I certify that this patient is under my care. The rehabilitation services prescribed by me are medically necessary and in accordance with a plan established and periodically reviewed by me.

Physician/Practitioner Name (printed):

Physician/Practitioner Signature: **Date:**

Fax to **(682) 738-3272** (toll-free) Any questions? Call **(682) 738-3056** or online at **www.SHBHTherapy.com**