



Pediatric Home Health Care
Please fax your referral to (214) 575-2727

Patient Name: DOB: [ ] M [ ] F

Street Address: Zip Code

Treating Address: [ ] Day-time [ ] After-school

Parent Name:

Home Phone: Alternate Phone:

Primary Language: [ ] English [ ] Spanish [ ] Translator needed

Insured Name: Medicaid #:

Evaluate & Treat Disciplines: [ ] Speech Therapy [ ] Occupational Therapy [ ] Physical Therapy
[ ] Feeding/Dysphagia [ ] Language/Cognitive

- IDC-9 Diagnosis
[ ] 299.00 Autism [ ] 315.39 Other Speech/Lang Disorder [ ] 723.5 Torticollis
[ ] 307.0 Stuttering [ ] 315.4 Developmental Coordination [ ] 758.0 Down Syndrome
[ ] 314.00 ADD [ ] 315.9 Unspecified Delay Development [ ] 781.3 Lack of Coordination
[ ] 314.01 ADHD [ ] 343.8 Cerebral Palsy [ ] 783.42 Delayed Milestones
[ ] 315.2 Learning Disability [ ] 389.00 Hearing Loss [ ] 784.40 Voice Disturbance
[ ] 315.31 Expressive Language Disorder [ ] 438.81 Apraxia [ ] 787.2 Dysphagia
[ ] 315.32 Mixed Language Disorder [ ] 719.7 Difficulty in walking [ ] Other \_\_\_\_\_
[ ] \_\_\_\_\_

Clinic Information:

Address:

Phone: Fax:

Referral Coordinator:

I certify that this patient is under my care and authorize the evaluation and treatment of the patient if deemed necessary.

Physician name: (printed)

Physician signature: Date: