50 Pleasant Street, Unit #1
Norwich, CT 06360
Phone: 860.222.3122
Fax: 860.222.8481
info@colemanpediatrictherapy.com
www.colemanpediatrictherapy.com

PLEASE FILL OUT ALL SECTIONS TO ASSIST WITH THE REFERRAL PROCESS

Patient's name: ______________________________ **Date of Birth**: _______________________

Phone Number: ______________________________ **Parent Name**: _______________________

Address: ____

Insurance Plan: _________________________ **Member ID:** ______________________________

OT Evaluation & Treatment
___x/week for ____ weeks

ICD-10 Codes:

- ☐ F84.0: Autistic Disorder
- ☐ R27.9: Lack of Coordination
- ☐ M62.81: Muscle weakness (generalized)
- ☐ F90.9: Attention-Deficit/Hyperactivity, Unspecified Type
- ☐ F82: Specific Developmental Disorder of Motor Function
- ☐ Other: _______________________________________
- ☐ Other: _______________________________________
- ☐ Other: _______________________________________

To address:

- ☐ Functional Strengthening-Upper Extremity/Core
- ☐ Sensory Processing Skills
- ☐ Executive Functioning Skills
- ☐ Fine Motor Skills
- ☐ Visual Motor/Visual Perceptual Skills
- ☐ Feeding/Oral Motor Skills
- ☐ Daily Living/Self Care Activities

Provider's Signature: ______________________ **Date**: _________________________________

Print Name: _______________________________ **Provider NPI:** _________________________

Address: ____

Phone Number: ___________________________ **Fax Number** : _________________________

WE APPRECIATE THIS REFERRAL!