Referral for Occupational Therapy Evaluation

Learning Coach LLC | Phone: (360) 207-4560 | Fax: (360) 325-7720 | www.LearningCoachWA.com

Family Information

- ➢ Student / Client / Child Name_____
- ➢ Date of Birth_____
- ➢ Guardian / Legal Representative Name_____
- ➢ Relationship to Client_____
- ➢ Phone Number _____
- ➢ Email _____

Occupational Therapy Clinic Information

- ➢ Occupational Therapy Practice: Learning Coach LLC_____
- ➢ Occupational Therapy Practice Contact: 360-207-4560; LearningCoachWA.com

Medical Examiner Information

- ➢ Name and Credentials _____
- ➢ Office Phone Number_____Fax:_____
- ➢ Office Address_____

I, the undersigned medical examiner, affirm that I have provided sufficient medical examination to determine whether the above client's occupational functioning is adversely impacted by one or more of the conditions below:

Developmental Conditions, Scholastic

_____ F81.9 Developmental disorder of scholastic skills, unspecified
_____ F82- Specific developmental disorder of motor function
_____ F84.0 Autistic disorder
_____ F84.5 Asperger's syndrome
_____ F84.9 Pervasive developmental disorder, unspecified
_____ F88- Other disorders of psychological development
_____ Other_____

Anxiety

_____ F41.1 Generalized anxiety disorder

_____ F41.9 Anxiety disorder, unspecified

_____ Other_____

Intellectual Disability

_____ F70 - Mild intellectual disabilities

_____ F71 - Moderate intellectual disabilities

_____ Other_____

Sensory Processing / Executive Functioning

_____ R27.8- Other lack of coordination (includes Dysgraphia, Dysmetria, Dyspraxia)

_____ R41.840- Attention and concentration deficit

_____ R41.9 Unspecified symptoms and signs involving cognitive functions and awareness

_____ R44.8- Other symptoms and signs involving general sensations and perceptions

_____ R46.3 Overactivity

_____ R46.4 Slowness and poor responsiveness

_____ R62.0 Delayed milestone in childhood

_____ Other_____

Occupational Therapy Evaluation is

_____ RECOMMENDED at this time.

_____ NOT RECOMMENDED at this time.

If an occupational therapy evaluation indicates the condition causes an adverse impact in an area of the client's functioning, I, the undersigned medical examiner, prescribe Therapeutic Activities (CPT 97530) and/or Sensory Integrative Techniques (CPT 97533) to habilitate and/or rehabilitate the client's functioning.

Medical Examiner Signature _____Date _____