# Referral for Occupational Therapy Evaluation

*Please fill out this form and fax it to Learning Coach LLC at (360) 325-7720, or have the client bring it to their initial occupational therapy evaluation.*

**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_____
- ➢ Office Address_____

*I, the undersigned medical examiner, affirm that I have provided sufficient medical examination to determine whether the above client's daily 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 _____