# OCCUPATIONAL THERAPY REFERRAL

melmed center™

Patient Name:_____Date of Birth:_____Age:_____

Parent(s) Name:_____Tel # 1: _____

Address:_____Tel # 2: _____

**MEDICAL INFORMATION**

Referring Doctor: _____

Diagnoses:_____

Reason for Referral:

____Fine Motor Skills
____Gross Motor Skills
____Sensory Processing/Integration
____Visual Perception
____Other_____
____Handwriting
____Self-care Skills
_____SIPT Testing

Service(s) Requested:____Occupational Evaluation_____OT Therapy Treatment

Has this child been previously evaluated by an occupational therapist? ___Yes___No

If yes, please provide a copy of the evaluation and/or OT progress notes to Melmed Center.

Comments:

_____
_____
_____
_____
_____

Physician Signature:_____Date:_____

Address:_____Phone:_____

For Melmed Center Only:

Appointment Day:_____Date:_____Time:_____

Estimated Evaluation Time:_____Therapist: _____

Revision 10/11