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