Occupational Therapy Referral Form

Patient Name: _____ Patient's DOB: _____/_____/_____

Parent/Caregiver Name: _____ Phone Number: _____

Reason for Referral (Check all that apply):

__ Aggressive or controlling behavior, craving attention
__ Avoidance of getting messy, doesn't like hands dirty
__ Avoidance of physical activity
__ Bedwetting
__ Behavioral (Please circle: Afraid / Anger / Anxiety / Avoids / Frustrates / Tires)
__ Blinks excessively to focus on objects
__ Bowel Syndrome
__ Clumsy or uncoordinated
__ Confused handedness
__ Constantly feeling overwhelmed
__ Cycles of hyperactivity and extreme fatigue
__ Depression, isolation, withdrawal
__ Difficulties with vision, reading, or writing
__ Difficulty adapting to change
__ Difficulty catching a ball
__ Difficulty following directions or movement instructions
__ Difficulty judging distance, depth, space, and speed
__ Difficulty sitting still
__ Difficulty walking up stairs
__ Easily distracted, poor concentration, difficulty filtering out extraneous stimuli
__ Easily fatigues, irritable under fluorescent lighting
__ Easily triggered anger and/or emotional outbursts
__ Eating disorder(s)
__ Elective mutism
__ Eye tracking problems
__ Extreme fear of failure, perfectionism
__ Extreme shyness, fear in groups
__ Fear of heights
__ Feeling stuck
__ Fine visual-motor (Reason: _____)
__ Gross visual-motor (Reason: _____)
__ Hip rotation to one side
__ Hypersensitivity to light, movement, sound, touch, and smell
__ Insecurity, low self-esteem
__ Limitation of field of vision
__ Low tolerance to stress
__ Messy and clumsy eating
__ Motion sickness/Car sickness
__ Muscle tone too weak or too tight, low muscle tone
__ Pain in neck and/or back
__ Phobias
__ Poor balance and coordination
__ Poor digestion (tendency towards hypoglycemia)
__ Poor short-term memory
__ Poor skills to differentiate between textures
__ Poor stamina
__ Poor swimmer
__ Posture (Please circle: Sits too close / Sits too far / Leans / Covers an eye)
__ Reading/writing problems
__ Scoliosis
__ Sensory-Integration (Includes SID, ADHD, Autism, PDDNOS)
__ Separation anxiety, clinging to a loved one
__ Shallow, difficult breath control
__ Skipped crawling
__ Sleep disturbances, difficulty settling to sleep
__ Speech or articulation difficulties
__ Squirming or fidgeting
__ Stiff, jerky movements
__ Tendency to be cross-eyed
__ Tendency to be selfish, egocentric, or impatient
__ Tension and hyperextension of legs w/ stiffness of the lower body
__ Toe walking
__ Torticollis
__ Traumatic brain injury (Including stroke, car accidents, in utero)
__ Trouble crossing midline
__ Trouble staying on task
__ Underlying anxiety or negativity
__ Unusual mouth or tongue movements while writing
__ Vision disorder(s)
__ Visual memory
__ Visual organization
__ Visual perception (trouble with faces, objects, conceptualization)
__ Visual sequencing
__ Visual, speech, auditory difficulties
__ "W" sitting/leg positioning when floor sitting
__ Weak immune system, asthma, allergies, and infections
__ Withdrawal from touch
__ Writing (Please circle: Legibility / Sizing / Spacing / Staying on line)

Patient also has issues in the following/or is undergoing:

__ ADHD or ADD
__ Autism Spectrum or PDDNOS
__ Auditory Processing
__ Behavioral Issues
__ Dyslexia
__ Fine Motor Difficulties
__ Gross Motor Difficulties
__ Handwriting Difficulties
__ Neurological
__ Nutritional (Dietary or Taste) Difficulties
__ PANDAS
__ Primitive Reflexes
__ Sensory Integration
__ Spatial Relation
__ Other _____

Helping Hands, Inc. · 2049 Jefferson Davis Highway · Stafford, VA 22554 · Phone: 540-657-1423 · Fax: 540-657-1424

Patient Name: _____ Patient's DOB: _____/_____/_____

Parent/Caregiver Name: _____ Phone Number: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Has child received therapy services prior to this referral? _____ YES _____ NO

If yes, when? _____ If yes, where? _____

Helping Hands, Inc. accepts the following insurances: Aetna HMO/PPO, Anthem BCBS, Anthem BCBS Federal Employee Plan, CareFirst BCBS, Cigna, Kaiser Permanente, Tricare Standard and Prime, and Virginia Premier HMO.

Primary Insurance Coverage for Child: _____

ID # _____ Group # _____

Effective Date: _____ 1-800 # from Back of Card: _____

Policy Holder: _____ Policy Holder's DOB: _____ Relation to Patient: _____

Secondary Insurance Coverage for Child: _____

ID # _____ Group # _____

Effective Date: _____ 1-800 # from Back of Card: _____

Policy Holder: _____ Policy Holder's DOB: _____ Relation to Patient: _____

Helping Hands, Inc. will send a copy of the evaluation conclusion and proposed treatment plan to the ordering physician before therapy is initiated. Please be sure to provide us with the following information:

Referring Physician's Name: _____ Date: _____

NPI: _____

Phone Number: _____ Fax Number: _____

Thank you in advance for referring your patient to us. Please note, new patient appointments are typically scheduled 2-3 months from the initial inquiry. If you have questions, please be sure to contact us at 540-657-1423.