



**Developmental Therapy Associates, Inc.**

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**PHYSICIAN REFERRAL FOR THERAPY         OT         Speech (Check one)**

Please have your child's physician complete this form.

**Child's Name:** \_\_\_\_\_ **Parent Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Statement of Diagnosis:**

\_\_\_\_\_  
\_\_\_\_\_

**Pertinent Medical History:** *(Please list any information that therapist should know in treating this child, such as seizures, precautions, medications).*

\_\_\_\_\_  
\_\_\_\_\_

**Therapy Services Requested:**

**Evaluation:**

- \_\_\_\_\_ Proceed with therapy evaluation.
- \_\_\_\_\_ List specific evaluation measures requested \*(optional).

\_\_\_\_\_

**Therapy:**

- \_\_\_\_\_ Proceed with appropriate therapy as determined by the evaluation.
- \_\_\_\_\_ List specific therapeutic goals \*(optional).

\_\_\_\_\_

<b>Date</b>	_____, MD
<b>Phone Number</b>	<b>Physician's Signature</b>
<b>Street Address</b>	<b>Physician's Name Printed</b>
<b>City, State, Zip</b>	<b>Physician's UPIN# / NPI #</b>

*Please Fax to 919-403-1407. Thank you!*