



OCCUPATIONAL THERAPY / PHYSICAL THERAPY / SPEECH PATHOLOGY SERVICES ORDER FORM

FAX form to 513-803-1111 or 1-866-877-8905

3333 Burnet Ave., MLC 9014 Cincinnati, OH 45229-3039 1-800-344-2462

(After faxing form, have family call for appointment.)

Forms: www.cincinnatichildrens.org/consults

PATIENT INFORMATION

Patient's Name CCHMC MR # (If available) Date of Birth Home Phone Alt Phone

REASON FOR REQUEST

Reason for request / Specific question(s) to be answered: 1. 2.

History / Symptoms / Special needs / Diagnosis (required):

Check here if additional clinical information is included with this order. Patient Status: Outpatient Inpatient Transitioning to Outpatient College Hill Shriners Hospital Other

SERVICES REQUESTED

SPEECH PATHOLOGY

Evaluation Requested: General Speech/Language Specialty Evaluations: Auditory Processing Augmentative Communication Cognition/Language Learning Myofunctional/Tongue Thrust Oral-Motor/Feeding/Swallowing Pre-Cochlear Implant Resonance/Velopharyngeal Function Selective Mutism Stuttering/Fluency Vocal Cord Dysfunction Other:

Clinics/Teams/Radiology Study: Hearing Impaired Clinic High Risk Infant Clinic Swallow Study: Video Swallow Study (VSS)

Outpatient Neuro Rehab Team (ONRT) at Drake OT PT SP

OCCUPATIONAL THERAPY AND/OR PHYSICAL THERAPY

Reason for Referral: Evaluate and Treat Evaluate Only Ortho/Sports Medicine Patient Exhibits Problems With: Activities of Daily Living Gross Motor Skills Range of Motion Cardiovascular Handwriting Sensory Processing Development Oral-Motor/Feeding Skills Strength Endurance Mobility Transfers Fine Motor Skills Pain Management Functional Skills Perceptual Motor Skills

Additional information: Precautions for Therapy:

Weight Bearing Precautions: Non Weight Bearing Toe Touch Partial R L As Tolerated R L R L

Provide Patient With: Wheelchair/Seating Recommendations Wheelchair Clinic Team Evaluation (complex seating needs) Lower Extremity Serial Cast Upper Extremity Serial Cast Lower Extremity Splint Upper Extremity Splint Other:

Provide Patient with Iontophoresis with Dexamethasone: Strength: 4 mg/mL vial Route: transdermal Quantity: 2.5 mL (adjustment based on size of treatment area) Frequency: 2-3 times/week; or other frequency (must specify) Duration: 4-6 weeks; or other duration (must specify)

REQUESTING PRACTITIONER / GROUP

Office Name Physician Name Office Address Telephone Signature/Credentials of ordering Practitioner Fax

Print Name (if different from physician above) Date

