



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

CCHMC MR# _____

**OCCUPATIONAL THERAPY / PHYSICAL THERAPY /
SPEECH PATHOLOGY / AUDIOLOGY
SERVICES ORDER FORM**

FAX form to 513-803-1111 or 1-866-877-8905
(After faxing form, have family call for appointment.)
Forms: www.cincinnatichildrens.org/consults

PATIENT INFORMATION

Today's Date _____ Patient Name _____
Date of Birth _____ Home Phone _____ Alt Phone _____

REASON FOR REQUEST

List reason(s) for request / specific question(s) to be answered: _____

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

- General Speech/Language
 Specialty Evaluations:
 Auditory Processing Oral-Motor/Feeding/Swallowing Stuttering/Fluency
 Augmentative Communication Pre-Cochlear Implant Vocal Cord Dysfunction
 Cognition/Language Learning Resonance/Velopharyngeal Function Other: _____
 Myofunctional/Tongue Thrust Selective Mutism
- Clinics/Teams/Radiology Study:
 Hearing Impaired Clinic High Risk Infant Clinic Swallow Study: Video Swallow Study (VSS)
 Outpatient Neuro-Rehabilitation Team (ONRT) at Drake OT PT SP

AUDIOLOGY

- Evaluation Requested:
 Routine Hearing Testing *OR*
 Auditory Brainstem Response (ABR or BAER)
- Note: The evaluation(s) completed will depend on child's developmental level*
- Specialty Evaluations and Treatment Requested:
 Aural Rehabilitation Evaluation & Therapy
 Central Auditory Processing Evaluation (CAPE) & Follow-up
 Cochlear Implant Evaluation & Follow-up
 Hearing Aid Evaluation & Follow-up
 Vestibular (Balance) Evaluation & Follow-up
 Other: _____

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 Fine Motor Skills Mobility Range of Motion Cardiovascular Functional Skills
 Oral Motor/Feeding Skills Sensory Processing Development Gross Motor Skills Pain Management Strength
 Endurance Handwriting Transfers Perceptual Motor Skills Other: _____

Additional information: _____

Precautions for Therapy: _____

Weight Bearing Precautions: Non Weight Bearing R L Toe Touch R L Partial R L As Tolerated 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
 Provide Patient Iontophoresis with Dexamethasone: Strength: 4 mg/mL vial Route: Transdermal
Frequency: 2-3 times/week; or other frequency (must specify) _____
Duration: 4-6 week; or other duration (must specify) _____
 Other: _____

REQUESTING PRACTITIONER / GROUP

Office Name _____ Practitioner Name _____

Office Address _____

Telephone _____ Fax _____

Signature/Credentials of Ordering Practitioner _____ Print Name _____ Time/Date _____

