Cincinnati Children's
changing the outcome together

OCCUPATIONAL THERAPY / PHYSICAL THERAPY / SPEECH-LANGUAGE PATHOLOGY / AUDIOLOGY SERVICES ORDER FORM

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

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

PATIENT INFORMATION

Today's Date: _____ Patient Name: _____
Date of Birth: _____ Patient Gender: _____ Mother's Name: _____
CCHMC MR # (if available): _____ 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

AUDIOLOGY

Evaluation Requested:
☐ Routine Hearing Testing/Audiologic Evaluation *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 Physical Therapy

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: _____

THE PERLMAN CENTER FOR CEREBRAL PALSY/NEUROMOTOR DISORDERS

☐ Comprehensive, Interdisciplinary Early Intervention Program (OT, PT, Speech, Teacher & Social Worker) Evaluate/Treat
☐ Assistive Technology Evaluate/Treat ☐ Augmentative Communication ☐ Seating/positioning/mobility
☐ Computer Access ☐ Aquatic Therapy ☐ Cortical Visual Impairment Evaluate/Treat
Additional Information: _____

SPEECH-LANGUAGE PATHOLOGY

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

REQUESTING PRACTITIONER / GROUP

Office Name: _____ Practitioner Name: _____
Office Address: _____
Telephone: _____ Fax: _____

Signature/Credentials of Ordering Practitioner Printed Name Date Time