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CCHMC MR# \_\_\_\_\_

**OCCUPATIONAL THERAPY / PHYSICAL THERAPY /  
SPEECH-LANGUAGE 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: <http://www.cincinnatichildrens.org/referrals>

**PATIENT INFORMATION**

Today's Date \_\_\_\_\_ Patient Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Patient Gender \_\_\_\_\_ Mother's Name \_\_\_\_\_  
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-LANGUAGE PATHOLOGY**

- General Speech/Language
- Specialty Evaluations:
  - Language 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
  - Voice
  - Other: \_\_\_\_\_
- Clinics/Teams/Radiology Study:
  - Hearing Impaired Clinic
  - Outpatient Neuro-Rehabilitation Team (ONRT) at Drake
  - High Risk Infant Clinic
  - Swallow Study: Video Swallow Study (VSS)
  - Voice Clinic

**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: \_\_\_\_\_

**REQUESTING PRACTITIONER / GROUP**

Office Name \_\_\_\_\_ Practitioner Name \_\_\_\_\_  
Office Address \_\_\_\_\_  
Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Signature/Credentials of Ordering Practitioner \_\_\_\_\_ Print Name \_\_\_\_\_ Time/Date \_\_\_\_\_

