Cincinnati Children's
changing the outcome together
3333 Burnet Ave., MLC 9014
Cincinnati, OH 45229-3039
1-800-344-2462

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
- ☐ High Risk Infant Clinic
- ☐ Swallow Study: Video Swallow Study (VSS)
- ☐ VPI Clinic
- ☐ Outpatient Neuro-Rehabilitation Team (ONRT) at Drake
- ☐ 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