Pediatric rehabilitation referral fax form

Legacy Salmon Creek Medical Center

LEGACY HEALTH | SALMON CREEK MEDICAL CENTER

2121 N.E. 139th St.
Medical Office Building A, Suite 200
Vancouver, WA 98686-2742

Program phone: **360-487-1778**
Program fax: **360-487-1779**
☐ Legacy Salmon Creek tax ID: 33-1065485

Patient name: _____

MR #: _____

DOB: _____

Parent/guardian: _____

Parent/guardian/preferred contract number(s) _____

Insurance: _____ ID number: _____

Primary care: _____ Phone number: _____ Fax number: _____

The following services are requested for your patient.

- **Primary care physician**: Please sign below to indicate approval of these services and fax to our office.
- **Referral coordinator**: Please submit referral to insurance company, if necessary, for number of visits indicated.

If you have any questions, contact _____ at _____. Thanks!

Requestor: _____ Today's date: _____

Assessment	**Due (Month/Year)**	**Provider**	**Appointment date/time**
☐ Infant hearing evaluation			
☐ ABR non-sedated evaluation			
☐ Sedated auditory brainstem evoked response (ABR) under general anesthesia			
☐ Occupational therapy evaluation			
☐ Physical therapy evaluation			
☐ Speech language evaluation			
☐ SLP fluency evaluation			
☐ AAC evaluation w/: ○ SLP ○ SLP & OT			
☐ ADOS test w/: ○ SLP ○ SLP & OT			
☐ Videofluoroscopy, VP function, w/SLP eval (MBSE)			
☐ MBSS w/dysphagia eval (MBSE)			
☐ Feeding/dysphagia eval (no radiology)			

Requested therapy treatment(s)	**Provider**	**Proposed start date**	**Proposed end date**	**Frequency**	**Number of visits**
☐ Aquatic therapy					
☐ Augmentative communication therapy					
☐ Dysphagia/oral feeding therapy					
☐ Occupational therapy					
☐ OT/PT post botox casting					
☐ OT splinting + three visits					
☐ Physical therapy					
☐ Speech language therapy					

Other (please describe below)	**Due (month/year)**	**Provider**	**Appointment date/time**
☐ _____			

Auth #: _____ Number of Visits: _____ Date range: _____

Medical ICD10 code(s): _____ Therapy ICD10 code(s): _____

Physician/PCP signature: _____ Date: _____

The referral form provides medical authorization for services requested and assists in verification of insurance authorization for services to be rendered. Please complete the referral form per instructions below to refer your patients. Telephone referrals are also welcomed.

Please complete only the portions of the form listed below. We will complete remaining items as needed.

Top portion of referral form

- Patient name
- Patient DOB
- Insurance name
- Insurance ID number
- Primary care provider name
- Primary care phone number
- Primary care fax number

Middle portion of referral form

- For evaluation referrals, please check procedure(s) being requested in "Assessment" section.

Written descriptions of assessment procedures offered are available on request; description will be sent to family at time appointment is scheduled to help them know what to anticipate in the assessment procedure.

- For therapy treatment referrals, please check requested therapy or therapies **and** requested frequency and number of visits.

You will receive periodic progress reports; you may also receive subsequent request(s) to extend PCP authorization beyond initial therapy request if continued therapies appear warranted.

Lower portion of referral form

- Medical ICD10 code(s)
- Physician/PCP signature and date

Please fax completed form to our program. Thank you for your referral.

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