CONNECTION
THERAPY CLINIC

Phone
(949) 385-1410
Email
info@connectiontheraycliniс.com
Connectiontherapyclinic.com

Referral for Occupational Therapy

Dear Physician:

Your patient ______________________________ is seeking occupational therapy services with us.

Although occupational therapists outside of a hospital are not required to work under a physician's referral, insurance companies often **require** documentation of a physician's referral for consideration of reimbursement. In order to facilitate processing of insurance claims, a physician's referral with diagnosis is highly recommended.

In the absence of other diagnoses, the following may best describe the difficulties experienced by many of the children seen in our clinic:

M62.81 Muscle Weakness (Generalized)
G70.2 Congenital and/or Developmental Myasthenia or
F82 Specific Developmental Disorder of Motor Function

If the child has adequate coordination but has suspected sensory issues, some physicians use the diagnosis
F93.9 Childhood Emotional Disorder, Unspecified or
G96.9 Disorder of Central Nervous System, unspecified

Given a release of information, we would be happy to speak with you if there are questions about a diagnosis or our services.

Please fill out the attached, accompanying form and email it to the address below, info@connectiontherapyclinic.com.

Thank you for your support of this child and family.

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Referral for Occupational Therapy

Child's Name: ________________________________ Date of Birth _____________

Occupational Therapy for 45 minutes: ______ Once a week ______ Twice a week

Diagnosis/diagnoses: If more than one diagnosis is used please indicate primary with an *

___ M 62.81 Muscle Weakness (Generalized)
___ G70.2 Congenital and/or Developmental Myasthenia
___ F82 SpecificeDevelopmenal Disorder of Motor Function
___ R29.3 Abnormal Posture, Head Position
___ G80 __ Cerebral Palsy; specify type: ____________________
___ G96.9 Disorder of Nervous System, Unspecified
___ R63.3 Feeding Difficulties, Oral Aversion
___ F50.9 Eating Disorder, Unspecified
___ F51.01 Primary Insomnia, Difficulty Initiating or Maintaining Sleep
___ F84.0. Autistic Disorder. ___ F84.2 Rett Syndrome; ___F84.5 Asperger's Syndrome
___ Q99.2 Fragile X Syndrome
___ Q90.9 Down Syndrome, Unspecified
___ F 90.1 ADHD, Predominantly Hyperactive Type; ___ F90.2 ADHD, Combined Type
___ F90.0 ADHD, Predominantly Inattentive Type; ___ F90.9 ADHD, Unspecified Type
___ F41.1 Generalized Anxiety Disorder; ___ F41.9 Anxiety, Unspecified;
___ F40.8 Other Phobic Anxiety Disorders
___ F93.9 Childhood Emotional Disorder, Unspecified
___ Other: ____ (specify)

Physician name, address, and license number:

I verify that the services requested are medically necessary for the above-named patient.

Signature : ________________________________ Date _____________

NPI # _____________

Referral for Speech Therapy

Dear Physician:

Your patient ______________________________ is seeking speech therapy services with us.

Although speech therapists outside of a hospital are not required to work under a physician's referral, insurance companies often **require** documentation of a physician's referral for consideration of reimbursement. In order to facilitate processing of insurance claims, a physician's referral with diagnosis is highly recommended.

Some common diagnoses that our clients get treated for are:

F80.9 (Other Developmental Disorder of Speech)
F80.0 Phonological Disorder
F80.1 Expressive Language Disorder
F80.2 Mixed Receptive/Expressive d/o

Given a release of information, we would be happy to speak with you if there are questions about a diagnosis or our services.

Please fill out the attached, accompanying form and email it to the address below, info@connectiontherapyclinic.com.

Thank you for your support of this child and family.

Laguna Niguel, CA

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Connectiontherapyclinic.com

Referral for Speech Therapy

Child's Name: ______________________________________ Date of Birth ________________

Occupational Therapy for 30 minutes: __ Once a week __ Twice a week. __ Three times a week

Diagnosis/diagnoses: If more than one diagnosis is used please indicate primary with an *

___ F40.8 Other Phobic Anxiety Disorders

___ F 80.0 Phonological disorder; ___ F80.1 Expressive language disorder; ___ F80.2 Mixed receptive-expressive language disorder; ___ F80.4 Speech and language development delay due to hearing loss; ___ F80.81 Childhood onset fluency disorder; ___ F80.89 Other developmental disorders of speech and language; ___ F80.9 Developmental disorder of speech and language, unspecified Communication disorder NOS Language disorder NOS

___ F81.0 Specific reading disorder

___ F94.0 Selective mutism; ___ F94.8 Other childhood disorders of social functioning

___ F95.1 Chronic motor or vocal tic disorder

___ F98.29 Other feeding disorders of infancy and early childhood; F98.5 Stuttering [stammering]

___ R47.01 Aphasia; ___ R47.02 Dysphasia; ___ F47.1 Dysarthria and anarthria; ___ R47.81 Slurred speech; ___ R47.82 Fluency disorder in conditions classified elsewhere Stuttering in conditions classified elsewhere Code first underlying disease; ___ R47.89 Other speech disturbances; ___ R47.9 Unspecified speech disturbances

___ R48.2 Apraxia, verbal

___ I69.928 Other speech and language deficits following unspecified cerebrovascular disease

___ F84.0 Autistic Disorder; ___F84.2 Rett Syndrome; ___F84.5 Asperger's Syndrome; ___F84.9

___ Q99.2 Fragile X Syndrome; ___ Q90.9 Down Syndrome, Unspecified

___ Other: ____ (specify)

Physician name, address, and license number:

I verify that the services requested are medically necessary for the above-named patient.

Signature : ___________________________________ Date _______________

NPI # _______________