PEDIATRIC OCCUPATIONAL THERAPY REFERRAL FORM

Name: ____________________

Date of Birth (yyyy/mm/dd)**:** ____________ **Age:** ____

Address: ____________________

____

Phone: (   ) ____________________

Email: ____________________

Parents/Guardian: ____________________

Date (yyyy/mm/dd)**:** ____________________

Family Doctor: ____________________

Family Doctor's Address: ____________________

____

____

Referral By: ____________________

School: ____________________

Address: ____________________

Phone / Fax: ____________________

Contact Person & Title: ____________________

Service(s) Required:

- ☐ Occupational Therapy Assessment & Report
- ☐ Assessment Only (No Report)
- ☐ Occupational Therapy Intervention: (Therapy Sessions)
- ☐ Interest In Group Therapy: (Social Skills, Behavior Management, Sensory Skills)
- ☐ Education & Training
- ☐ School Staff
- ☐ Parents

Please report some of the child's difficulties at school: ____________________

____

____

____

____

Diagnostic Data Attached:

- ☐ Work Samples.
- ☐ Clinical Reports (Speech Therapy, Psychology).
- ☐ Other Relevant Documents.