Crow Therapies
Pediatric Evaluation & Treatment Order

Patient's Name:_____ Date of Birth:_____ *(mm/dd/yyyy)* Insurance ID:_____

Required Documentation for Referrals:

O **Well Child Visit** OR **Most Recent Visit w/Concerns** O **ASQ or PEDS** O **Hearing Screening** *(Birth - 6 years. Speech referrals only)*

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Parent/Guardian: _____

Phone: _____ Cell: _____

Primary Insurance: _____ ID #: _____

Secondary Insurance: _____ ID #: _____

Primary Diagnosis (ICD 10):

☐ F84.0 Autistic Disorder
☐ R62.50 Developmental Delay
☐ R27.0 Ataxia Unspecified
☐ G80.9 Cerebral Palsy
☐ G40.0 Seizure Disorder NOS
☐ Q38.1 Ankyloglossia
☐ Q90.9 Down Syndrome
☐ P07 Premature Birth
☐ Other: _____

Precautions/Contraindications: _____

PHYSICIAN ORDERS

☐ SPEECH THERAPY
To evaluate & treat if indicated
Treatment Diagnosis (ICD 10):

☐ F80.2 Mixed receptive-expressive language disorder
☐ F80.0 Phonological disorder
☐ R48.8 Other symbolic dysfunctins
☐ R13.11 Dysphagia, oral phase
☐ R13.12 Dysphagia, oropharyngeal phase
☐ Other: _____

☐ OCCUPATIONAL THERAPY
To evaluate & treat if indicated
Treatment Diagnosis (ICD 10):

☐ F82 Disorder of Motor Function
☐ R62.0 Delayed Milestone in Childhood
☐ R27.8 Lack of Coordination
☐ Other: _____

I certify medical necessity for evaluation & treatment and attest that the Texas Health Steps Checkup is current. The family is aware that they must comply with all therapy plans of care and complete the recommended home exercise program.

_____ _____
Physician Signature Date

_____ _____
Print Physician Name Phone

_____ _____
Name of Supervising Physician *(if referred by NP/PA)* NPI