



Crow Therapies

Pediatric Evaluation & Treatment Order

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

Required Documentation for Referrals:

Well Child Visit OR Most Recent Visit w/Concerns ASQ or PEDS 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):

<input type="checkbox"/> F84.0 Autistic Disorder	<input type="checkbox"/> G80.9 Cerebral Palsy	<input type="checkbox"/> Q90.9 Down Syndrome
<input type="checkbox"/> R62.50 Developmental Delay	<input type="checkbox"/> G40.0 Seizure Disorder NOS	<input type="checkbox"/> P07 Premature Birth
<input type="checkbox"/> R27.0 Ataxia Unspecified	<input type="checkbox"/> Q38.1 Ankyloglossia	<input type="checkbox"/> Other: _____

Precautions/Contraindications: _____

PHYSICIAN ORDERS

<input type="checkbox"/> SPEECH THERAPY To evaluate & treat if indicated Treatment Diagnosis (ICD 10): <input type="checkbox"/> F80.2 Mixed receptive-expressive language disorder <input type="checkbox"/> F80.0 Phonological disorder <input type="checkbox"/> R48.8 Other symbolic dysfunctions <input type="checkbox"/> R13.11 Dysphagia, oral phase <input type="checkbox"/> R13.12 Dysphagia, oropharyngeal phase <input type="checkbox"/> Other: _____	<input type="checkbox"/> OCCUPATIONAL THERAPY To evaluate & treat if indicated Treatment Diagnosis (ICD 10): <input type="checkbox"/> F82 Disorder of Motor Function <input type="checkbox"/> R62.0 Delayed Milestone in Childhood <input type="checkbox"/> R27.8 Lack of Coordination <input type="checkbox"/> Other: _____
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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

 Print Physician Name

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

 Date

 Phone

 NPI

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