Oaklin Lane

Patient Name: _____
Patient Date of Birth: _____
Primary Contact: _____
Phone Number: _____

Physician's Referral/Prescription for Therapy

General Diagnosis: (Please check all that apply.)

__ F84.0 Autistic Disorder
__ F84.5 Asperger's Syndrome
__ F84.8 Pervasive Developmental Disorder NOS
__ F90.0 ADHD, Inattentive
__ F90.1 ADHD, Hyper
__ F90.2 ADHD, Combined Type
__ Q90.9 Down Syndrome, Unspecified
__G80.8 Cerebral Palsy NOS
__F70 Mild Intellectual Disabilities

Physical/Occupational Therapy

__ Q68.0 Congenital Torticollis
__ R27.8 Other Lack of Coordination
__ F82 Spec. Dev. Dis. of Motor Function
__ G96.9 Disorder of CNS, Unspecified
__ M62.81 Generalized Muscle Weakness
__ R62.0 Delayed Milestones

Speech-Language Therapy

__ F80.0 Phonological Disorder
__ F80.1 Expressive Language Disorder
__ F80.2 Mixed Rec.-Exp. Lang Disorder
__ F80.89 Other Dev. Speech Disorders
__ F80.81 Fluency Disorder (child onset)
__ F81.0 Specific Reading Disorder

Feeding/Oral Motor Therapy

__ R13.11 Dysphagia, Oral Phase
__ R13.12 Dysphagia, Oropharyngeal Phase
__ R13.13 Dysphagia, Pharyngeal Phase
__ R63.31 Pediatric Feeding Disorder, Acute
__ R63.32 Ped. Feeding Disorder Chronic
__ R63.30 Feeding Difficulties, Unspecified

__ Other Diagnosis (please list) _____

Medications/Recent Surgeries: _____

Precautions: __Universal Pediatric __ Fall Risk __ Aspiration __ VP Shunt __ Seizure Disorder

Contraindications: __ None __ Restrictions as follows: _____

Occupational and/or Physical Therapy is prescribed for:

Frequency: __ 2x / week __ Other_____

__ **Evaluate and Treat**

_ gross / fine motor via ther activities/ neuromuscular re-edu
_ strength/ coordination via ther ex / ther act / neuro re-edu
_ ADLs / self-care
_upper/ lower extremity orthotics
_ visual / perceptual activities
_adaptive equipment
_ myofascial release / soft tissue mobilization
_ gait training
_ oral motor / feeding therapy
_ Neuromuscular Electrical Nerve Stimulation (NMES)
_ Other: (please list)_____

Speech-Language/ Feeding Therapy is prescribed for:

Frequency: __ 2x / week __ Other_____

__ **Evaluate and Treat**

_ mixed expressive-receptive language therapy
_ expressive language therapy
_ receptive language therapy
_ articulation / sound production therapy
_ auditory processing therapy
_ voice therapy
_ fluency therapy
_ augmentative and alternative communication (AAC) device
_ oral motor/ swallowing/ feeding therapy
_ Neuromuscular Electrical Nerve Stimulation (NMES)
_ Other: (please list)_____

I certify that the patient's medical condition is sufficiently stable to permit safe therapy as described herein.
***For Medicaid patients: I certify the TX Health Steps checkup is current OR a developmental screening has been performed in the last 60 days.

Prescriber's Signature: _____ NPI: _____

Prescriber's Name & Credentials: _____ Phone: _____

Address: _____ Fax: _____

SEND COMPLETED FORM TO OAKLIN LANE · 8610 GREENVILLE AVE, #200 · DALLAS, TX · 75243 · PH: 469-310-1572

VIA: FAX: **972-521-3216** -OR- EMAIL: **PATIENTS@OAKLINLANE.COM**