



# Pediatric Home Health Care

Please fax your referrals to

Dallas: (214) 575-2727

Fort Worth: (817) 546-3679

Central Texas: (855) 715-3504

## Referring Agency / Physician Office:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  M  F

Street Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Treating Address: \_\_\_\_\_  
(if different from home)  Day-time  After-school

Parent / Guardian Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Emergency Phone Number: \_\_\_\_\_  
Emergency Contact / Relationship: \_\_\_\_\_

Primary Language:  English  Spanish  Other: \_\_\_\_\_  Translator needed

Medicaid #: \_\_\_\_\_ Medicaid Provider: \_\_\_\_\_  
Secondary Insurance  Yes  No Insurance Co. \_\_\_\_\_

Evaluate & Treat Disciplines:  Speech Therapy  Occupational Therapy  Physical Therapy  
 Feeding / Dysphagia  Language / Cognitive

## IDC-9 Diagnoses

- 299.00 Autism  315.39 Other Speech / Lang Disorder  723.5 Torticollis
- 307.0 Stuttering  315.4 Developmental Coordination Disorder  758.0 Down Syndrome
- 314.00 ADD  315.9 Unspecified Delay Development  781.3 Lack of Coordination
- 314.01 ADHD  343.8 Cerebral Palsy  783.42 Delayed Milestones
- 315.2 Learning Disability  389.00 Hearing Loss  784.40 Voice Disturbance
- 315.31 Expressive Language Disorder  438.81 Apraxia  787.2 Dysphagia
- 315.32 Mixed Language Disorder  719.7 Difficulty in walking  Other

Concerns / Info: \_\_\_\_\_

## Clinic / Physician Information:

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Referral / Care Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_

## PHYSICIAN REFERRAL ONLY (complete below):

I certify that this patient is under my care and authorize the evaluation and treatment of the patient if deemed necessary.

Physician name (printed): \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_