Referral Date: _____/_____/_____

Pediatric Therapies Referral/Intake Form

Client Name _____ Gender: _____

DOB _____/_____/_____ Parent informed of referral Y___ N___ N/A___

Initial Contact _____

Referral Source (***Abilities First Department/Self/Name/Organization***)_____

Parent/Guardian _____ **ESL?** ___ **if Y specify** _____

Address _____ **Preferred Phone** _____

_____ **Email** _____

Doctor: _____ **Location** _____

Phone _____ **Fax** _____

Doctor Referral ☐ Family Has ☐ To be brought to eval ☐ To be fax'd ☐ Already on file

Services Requested: ☐ PT ☐ OT ☐ ST ☐Feeding

Summer Specific: (check the ones you are interested in) *appropriateness for summer groups will be determined by the evaluating therapist

☐ Kids' Connect (Social Skills & Emotional Regulation)	☐ School Readiness Group	☐ OT Club
☐ Friends in STEP	☐Yoga (Group)	☐Yoga (Adaptive Individual)
☐ Work Readiness	☐Camp Connect	☐ Yoga (Caregiver+Child)

Reason for Referral: _____
_____

Diagnosis/History: _____
_____

Services	Circle one	If previously, when?	Where?
OT	Currently OR Previously		
PT	Currently OR Previously		
ST	Currently OR Previously		

Preferred therapy appointment day/times:_____

----------For Office Use Only----------

Appointment(s) **Evaluation** **Concur**

Day _____ Date _____/_____/_____ Time _____ Therapist _____
Day _____ Date _____/_____/_____ Time _____ Therapist _____

Funding: ☐Self pay ☐Medicaid ☐CareSource ☐BCMH ☐Insurance _____
☐Other _____

Intake Packet Sent: _____/_____/_____
Notes: _____

Revised: 12/3/2024