Lagniappe Pediatrics Rehab and Therapy
900 Camp Street, Suite 1224 | New Orleans, LA | (504) 318-6040 | LagniappePediatrics.com
Referral Form — Fax to (504) 389-4167 or bring to first appointment

ABA | OT | PT | SLP | Feeding | Behavioral Health
"A Little Something Extra for Every Child"

REFERRAL FORM

CHILD / CLIENT INFORMATION

Child's Full Name:

Date of Birth:

Address:

Age:

City / State / Zip:

Gender:

Child's Insurance Plan:

ID Number:

Parent / Legal Guardian Name and Phone:

Primary Care Doctor and Phone:

Primary Diagnosis:

THIS REFERRAL IS FOR

[ ] Physical Therapy (PT)

[ ] Speech-Language Pathology (SLP)

[ ] Occupational Therapy (OT)

[ ] Applied Behavior Analysis (ABA)

[ ] Feeding Therapy

[ ] Psychological Testing

Other: _____

REASON FOR REFERRAL — CHECK ALL THAT APPLY

[ ] Fine motor

[ ] Gross motor

[ ] Developmental delay

[ ] Speech delay

[ ] Behavior concerns

[ ] Social skills

[ ] Anxiety / regulation

[ ] Toileting

[ ] Self-care / ADL

[ ] Autism / ASD concerns

[ ] Language delay

[ ] Sensory processing

[ ] Feeding difficulties

[ ] ADHD concerns

Other:
_____

REFERRING PROVIDER INFORMATION

Referring Provider Name:

Practice / Facility Name:

Fax Number:

Mailing Address:

Date of Referral:

Notes / precautions / relevant history:

ABA THERAPY REQUIREMENTS

A signed physician order on script pad AND a Comprehensive Diagnostic Evaluation (CDE) report are required for ABA therapy.

[ ] Physician order attached
[ ] CDE / diagnostic report attached
[ ] Will be sent separately

REFERRING PROVIDER SIGNATURE

By signing below, I certify that the information provided is accurate and that the identified services are medically necessary for this patient.

Signature and Date:

OFFICE USE ONLY

Date Received:

Received By:

Insurance Verified? [ ] Yes [ ] No:

PA Submitted? [ ] Yes [ ] No:

Intake Date: