HAND IN HAND THERAPY
Guiding little hands. Growing big skills.

# Hand in Hand Therapy, PLLC

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## Referral Form

Child's Full Name: _____ Date of Birth: _____/_____/_____

Parent/Guardian Name(s): _____ Parent/Guardian Phone: _____

Parent/Guardian Email: _____

### Reason for Referral

(Please check all that apply)

☐ Fine motor concerns (writing, grasp, self-care)
☐ Gross motor concerns (balance, coordination, strength)
☐ Sensory processing difficulties
☐ Self-help skills (feeding, dressing, toileting)
☐ Social-emotional / behavior regulation
☐ Feeding concerns
☐ Other: _____

### Services Requested

☐ Initial Occupational Therapy Evaluation ($150)
☐ Ongoing Therapy Sessions ($125 per session)

### Referral Source

Referring Provider/Organization:

Contact Person: _____Phone:

Email: _____

Signature: _____ Date: _____

Hand in Hand Therapy is currently accepting **private pay clients only**. Payment is due at the time of service. Superbills can be provided upon request for out-of-network insurance reimbursement.