# BUILDING GREAT KIDS THERAPY
## Referral Form

**PATIENT INFORMATION** **Date of Referral:** _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Home phone #: _____ Parent/Parents:_____

Cell phone#:_____ Guardian:_____

Sex (circle one): Male Female Choose not to disclose E-mail Address: _____

Service Facilitator or Case Manager Name: _____ Ph#: _____ E-mail: _____

Service Facilitator or Case Manager Company: _____

Child Insurance_____Child Ins. ID #_____ Group #_____

**REASON FOR REFERRAL** Please list the child's health concerns, problems and diagnosis: _____

_____

_____

_____

**SCHOOL AND THERAPY SERVICES**

School/program currently attending:_____ Present grade: _____

Does this child have an IEP from school? Yes ☐ No ☐ What does it cover? _____

_____

_____

Special services received in school: OT ☐ PT ☐ Speech Therapy ☐ Resource services ☐

Other special services _____

_____

Additional Comments: _____

Private Therapy Attended: OT ☐ PT ☐ Speech Therapy ☐ Birth-to-3 ☐ ABA Therapy ☐

Please provide detail regarding which therapies attended, how many sessions per week, when each began and were terminated. If there are some currently taking place, please list that as well:_____

_____

*Please email this form to the email provided below or fax to (833)-699-2154. We will also need a referral from the child's primary care pysician faxed to our office as well before coordinating services. Thank you!

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