



# Quick Referral Form Pediatrics

Fax to: **903.596.7479**

Questions? Call 877-MY NURSE  
www.AtHomeHealth.org

Patient Information			
Patient Name:		Phone #:	<input type="checkbox"/> M <input type="checkbox"/> F
DOB:	Caregiver's Name:		
Address:		City/State/Zip:	
SS#:	Primary Language:		

Insurance Information			
Medicaid #:	Type of Insurance: <input type="checkbox"/> Traditional Medicaid <input type="checkbox"/> Commercial <input type="checkbox"/> Managed Care Medicaid		
Insured Name:	Policy #:	Group #:	
Insurance Co:	Ins Phone#:		

Diagnosis(es)		
<input type="checkbox"/> F80.0 Phonological Disorder	<input type="checkbox"/> P15.2 Sternomastoid injury d/t birth injury	<input type="checkbox"/> R47.81 Slurred speech
<input type="checkbox"/> F80.1 Expressive language disorder	<input type="checkbox"/> Q05.4 Unspecified Spina Bifida w/ hydrocephalus	<input type="checkbox"/> R47.82 Fluency disorder in conditions classified elsewhere
<input type="checkbox"/> F80.2 Mixed receptive-expressive language disorder	<input type="checkbox"/> Q68.0 Congenital deformity, sternocleidomastoid muscle	<input type="checkbox"/> R47.89 Other speech disturbance
<input type="checkbox"/> F84.0 Autistic Disorder	<input type="checkbox"/> Q90.9 Down Syndrome unspecified	<input type="checkbox"/> R48.0 Dyslexia and Alexia
<input type="checkbox"/> F84.9 Pervasive Dev. Disorder unspecified	<input type="checkbox"/> R13.0 Aphagia	<input type="checkbox"/> R48.2 Apraxia
<input type="checkbox"/> F90.1 ADHD predominantly hyperactive type	<input type="checkbox"/> R26.2 Difficulty walking not elsewhere classified	<input type="checkbox"/> R48.8 Other symbolic dysfunctions
<input type="checkbox"/> F90.9 ADHD unspecified type	<input type="checkbox"/> R26.89 Other abnormalities of gait and mobility	<input type="checkbox"/> R49.9 Unspecified voice and resonance disorder
<input type="checkbox"/> G71.2 Congenital Myopathies	<input type="checkbox"/> R27.0 Ataxia unspecified	<input type="checkbox"/> R62.50 Unspecified lack of normal physiological dev in childhood
<input type="checkbox"/> G80.9 Cerebral Palsy unspecified	<input type="checkbox"/> R27.9 Unspecified lack of coordination	<input type="checkbox"/> R62.0 Delayed milestone in childhood
<input type="checkbox"/> H90.2 Conductive Hearing Loss unspecified	<input type="checkbox"/> R47.02 Dysphasia	<input type="checkbox"/> R63.3 Feeding difficulties
<input type="checkbox"/> M62.81 Muscle Weakness	<input type="checkbox"/> R47.1 Dysarthria and anarthria	<input type="checkbox"/> Other:

Treatment Orders		
<input type="checkbox"/> Evaluate & Treat		
<input type="checkbox"/> Nurse evaluation for services	<input type="checkbox"/> Patient Education Program (PEP) for:	
<input type="checkbox"/> Speech/Swallowing Therapy	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Skilled Nursing Visits	<input type="checkbox"/> Private Duty Nursing	<input type="checkbox"/> Attendant Care

Physician Information		
Name:	Phone #:	FAX #:
License #:	NPI #:	TPI #:
Referred by:		

I certify the services indicated are essential and medically necessary to my patient's health and well-being. I further certify the care and services are provided according to a treatment plan developed and periodically reviewed by me.

Physician/NP/PA Signature: \_\_\_\_\_ Date: \_\_\_\_\_