at home healthcare
a VitalCaring Group Company

Quick Referral Form
Pediatrics

Fax to: 903.596.7479
Questions? Call 903-525-3740
www.AtHomeHealth.org

Patient Information			
Patient Name:	Phone #:	☐ M	☐ F
DOB:	Caregiver's Name:		
Address:	City/State/Zip:		
SS#:	Primary Language:		

Insurance Information		
Medicaid #:	Type of Insurance: ☐ Traditional Medicaid ☐ Commercial ☐ Managed Care Medicaid	
Insured Name:	Policy #:	Group #:
Insurance Co:		Ins Phone#:

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

Treatment Orders

☐ Evaluate & Treat

☐ Nurse evaluation for services	☐ Patient Education Program (PEP) for:	
☐ Speech/Swallowing Therapy	☐ Physical Therapy	☐ Occupational Therapy
☐ Skilled Nursing Visits	☐ Private Duty Nursing	☐ 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: _____