

Pediatric Therapy Referral

Pediatric Therapy Rehabilitation Services
Kootenai Health Campus
2003 Kootenai Health Way Coeur d'Alene, Idaho 83814
Phone: 208-625-5356 Fax: 208-625-5347

- Referral Attachment

Patient's Name: _____ Phone: _____
Last Name First Name MI

D.O.B. _____ Date of Onset: _____

Medical Diagnosis: _____

Requested Authorization:

Occupational Therapy:

Diagnosis: _____ ICD 10: _____

Frequency/Duration: _____

- | | |
|--|---|
| ☐ Evaluate and Treat | ☐ Sensory Motor Integration |
| ☐ Perceptual Integration | ☐ Cognitive Integration |
| ☐ Neurodevelopmental Treatment | ☐ Fine Motor & Writing Skill Development |
| ☐ ADL's/ IADL's | ☐ Therapeutic Listening Program |
| ☐ Aquatic Therapy | ☐ Family / Caregiver Training |
| ☐ Continue Current Plan of Care | ☐ Other: _____ |
| | ☐ Telehealth |

Physical Therapy:

Diagnosis: _____ ICD 10: _____

Frequency/Duration: _____

- | | |
|--|---|
| ☐ Evaluate and Treat | ☐ Balance / Coordination / Strength Training |
| ☐ Wheelchair Evaluation | ☐ Bowel & Bladder Biofeedback Program |
| ☐ Aquatic Therapy | ☐ Family / Caregiver Training |
| ☐ Gross Motor Skill Development | ☐ Developmental Follow-up Clinic |
| ☐ Continue Current Plan of Care | ☐ Telehealth |
| ☐ Mobility Training | ☐ Other: _____ |

Speech Therapy:

Diagnosis: _____ ICD 10: _____

Frequency/Duration: _____

- | | |
|--|--|
| ☐ Evaluate and Treat | ☐ Articulation / Phonology |
| ☐ Augmentative Communication Evaluation | ☐ Language Skill Development |
| ☐ Modified Barium Swallow (MBS) Study | ☐ Social Skills / Pragmatics |
| ☐ Cognition | ☐ Voice |
| ☐ Dysphagia | ☐ Fluency |
| ☐ Family / Caregiver Training | ☐ Continue Current Plan of Care |
| ☐ Developmental Follow-up Clinic | ☐ Neuromuscular Electrical Stimulation (NMES) for Dysphagia |
| ☐ Other: _____ | ☐ Telehealth |

Medical Professional Signature

Date

Time

Medical Professional Name (PLEASE PRINT)

Visit kh.org/Rehab to download and print our location maps

Patient Identification – Write in or attach patient label

Name: _____

MRN #: _____

CSN #: _____

Age/Sex: _____



- Referral Attachment
Form #720001-068
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