HOGG THERAPY
PEDIATRICS

PATIENT REFERRAL FORM

P: 859-353-3666 **F: 859-448-7077**

Date:_____ **Patient Name:**_____

Patient DOB:_____ **Patient Contact Number:**_____

Insurance Carrier and Member ID Number:_____

Refer to: Hogg Therapy Pediatrics / **Clinic Location:** Lexington___ Richmond___ Berea___ALL___
**If patient is willing to attend therapy at any of our locations please check ALL*

Service(s): (check any or all that apply):

Speech Therapy

F80.2 Receptive & Expressive Language Skills (includes reading) _____
F80.81 Fluency _____
F80.0 Articulation Disorder _____
R63.31 Pediatric Feeding Disorder, acute _____
R63.32 Pediatric Feeding Disorder, chronic _____
R63.39 Other Feeding Difficulties _____
OTHER: _____

Occupational Therapy

R62.0 Delayed Milestones in Childhood _____
R63.39 Other Feeding Difficulties _____
R62.50 Unspecified lack of normal physiological development in Childhood _____
F84.0 Autistic Disorder _____
OTHER: _____

Physical Therapy

R62.0 Delayed Milestones in Childhood _____
M62.81 Muscle Weakness (generalized) _____
M43.6 Torticollis _____
R62.50 Unspecified lack of normal physiological development in Childhood _____
OTHER: _____

For: Evaluate and Treat.

Referred by: _____

Provider and Credentials: _____

Provider Signature: _____ **Date:** _____

***Fax referral to 859-448-7077 ATTN: Referral Intake**

Please include patient medical history, patient insurance, and caregiver contact information.
To request the status of a patient referred to us at any time, select extension 106 to speak with Referral Intake. Thank you for entrusting your patients to us!