Referral Form

Sprouts Therapy
Pediatric Therapy Services // Occupational, Physical, Speech and Feeding Therapy
1425 Keolu Dr. Kailua, HI 96734
Fax: 808-444-3353 Phone: 808-260-9056

Client Name: _____Date of Birth: _____

Diagnosis/ICD10 code:_____(Confirmed___ /Provisional____)

Primary Insurance: _____Insurance ID Number: _____

Parent/Guardian Name: _____

Phone: _____

Address: _____

Common Diagnoses for Pediatric Therapy

OT: Autism, ADHD, Down Syndrome, Sensory Processing Disorder, Emotional Regulation Difficulties, Learning Disabilities/ Dyslexia, Delayed Milestones In Childhood, Visual Motor Difficulties, Ocular Motor and Functional Vision difficulties, Lack of Coordination, Muscle Weakness, Fine Motor Delay, Cognitive Deficit in Executive Functioning, Gross Motor Delay, Auditory Processing Disorder, Global Developmental Delay

PT: Autism, Down Syndrome, Cerebral Palsy, Scoliosis, Torticollis, Other Abnormalities of Gait and Mobility, Toe Walking, Gross Motor Delay, Hypotonia, Lack of Coordination, Muscle Weakness, Delayed Milestones In Childhood, Specific Developmental Disorder of Motor Function, Unspecified lack of expected normal physiological development in childhood

Speech and Language: Autism, Down Syndrome, ADHD, Cerebral Palsy, Articulation/Phonological Disorder, Unspecified Developmental Delay of Speech and Language, Mixed Expressive and Receptive Language Disorder, Speech Apraxia, Childhood Aphasia, Expressive Language Disorder, Fluency Disorder, Social Pragmatic Communication Disorder, S/L delay due to hearing loss

Feeding Therapy: Autism, Feeding Difficulties, Dysphagia, Parageusia, Oral Motor Delay

Primary Concerns:

Referring Client for: (Check Appropriate Item(s))

____ OT Evaluation/Treatment ___PT Evaluation/Treatment ____Speech/Language Evaluation/Treatment

____Feeding Evaluation/Therapy (Feeding involves both speech and occupational therapists)

Referring Agency/Physician: _____

Phone: _____Fax:_____

Physician signature: _____Date: _____