Clinical Services Order Form

Fax: 860-837-9898 or 860-545-9502

Date of order: _____

Patient Name: (Last)_____(First)_____ DOB:_____

Address:_____ City/State/Zip:_____

Sex (Legal): ☐M ☐ F Gender Identity: ☐M ☐ F ☐ Other _____ Needs Interpreter? ☐ Y ☐ N Language:_____

Phone #:_____ This visit is: Routine ** *Please call 833-733-7669 for all urgent requests* **

***Audiology** ICD 10 code:_____ (required)

☐ Evaluation & Treatment ☐ Vestibular & Balance ☐ Sedated BAER ☐ Other

Reason for referral:_____

Contraindications/precautions/history:_____

***Feeding Team** ICD 10 code:_____ (required)

(Ordering provider acknowledges they are ordering multiple services including Occupational Therapy, Nutrition & Speech Therapy)

☐ Evaluation ☐ Other

Reason for referral:_____ Allergies:_____

Contraindications/precautions/history:_____

***Nutrition** ICD 10 code:_____ (required)

☐Evaluation & Treatment ☐ Other

Reason for referral:_____Allergies:_____

***Occupational Therapy** ICD 10 code:_____ (required)

☐Evaluation & Treatment ☐Aquatic Therapy ☐Biofeedback ☐Feeding ☐Modalities ☐Splinting ☐ Other

Reason for referral:_____

Contraindications/precautions/history:_____

***Physical Therapy** ICD code: _____ (required)

☐Evaluation & treatment ☐Adaptive equipment ☐Aquatic therapy ☐Biofeedback ☐Pelvic floor ☐Schroth ☐Other

Reason for referral:_____

Contraindications/precautions/history:_____

***Speech-Language Pathology**

☐Evaluation & Treatment ☐Clinical swallow eval & treat ☐Flexible endoscopic eval of swallow ☐Passy-Muir Valve

☐Modified barium swallow/video fluoroscopic swallow study *please also order Fluoroscopy under Radiology ☐Other

Reason for referral:_____

Contraindications/precautions/history:_____

***Radiology** ICD 10 Code: _____ (required) Reason for exam/relevant history: _____

Modalities: Fluoroscopy / X-Ray / Ultrasound Exam Requested: _____

CT Exam requested _____ ☐without contrast ☐with contrast

MRI Exam requested _____ ☐without contrast ☐without/with contrast

Is Sedation or anesthesia required? ☐Yes ☐No *Please note: History and Physical Form required to schedule sedation

Referring provider:_____Phone:_____ Fax:_____

Primary Care provider: (if different from referring)_____ Is family aware of this referral? ☐ Yes ☐ No

Signature/Credentials of provider:_____ **Date:**_____