DYNAMIC
Therapy Specialists

Pediatric Therapy Referral Form

Patient's Name: _____
Patient's DOB: _____ Date of Referral: _____
Parent's Name: _____
Reason for Referral: _____

Please indicate where appropriate below to authorize your recommendation for the above patient to be evaluated and treated for the concerns stated above.

☑ Evaluate and Treat

Audiology:

- ❑ H93.299 other abnormal Auditory perception
- ❑ H65.20 chronic serous otitis media
- ❑ H90.0 conductive hearing loss, bilateral
- ❑ H90.11 conductive hearing loss unilateral right ear, with unrestricted hearing in the contralateral ear
- ❑ H90.12 conductive hearing loss unilateral left ear, with unrestricted hearing in the contralateral ear
- ❑ H90.3 sensorineural hearing loss, bilateral
- ❑ F80.2 (mixed exp/recep Lang disorder)
- ❑ H93.25 Central Auditory Processing disorder

Speech/Language

- ❑ F80.0 Phonological Disorder
- ❑ F80.1 Expressive Language Disorder
- ❑ F80.2 Mixed receptive-expressive language disorder
- ❑ F80.4 Speech and Language development delay due to hearing loss
- ❑ F80.81 Childhood onset fluency disorder
- ❑ F80.82 Social pragmatic communication disorder
- ❑ F80.89 Other developmental disorders of speech and language, unspecified
- ❑ F80.9 Developmental disorder of speech and language, unspecified
- ❑ F81.0 Specific reading disorder
- ❑ H93.25 Central Auditory Processing Disorder

Occupational Therapy:

- ❑ R62.0 delayed milestone in childhood
- ❑ R27.8 other lack of coordination
- ❑ F82 specific developmental disorder of motor function
- ❑ R20.9 Sensory Disturbance
- ❑ R45.87 Poor Impulse Control
- ❑ R46.89 Behavioral Concern

Physician's Signature: _____
Physician's Printed Name: _____
Date: _____
Clinic Name: _____
Phone Number: _____

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