



EVIDENCE-BASED.



DATA-DRIVEN.



CHILD-FOCUSED.



300 Regent Park Ct
Greenville, SC 29607



864-900-0250



864-272-3990 (Fax)

Referral for Physical Therapy or Occupational Therapy

Patient Information

Patient Name: Date of Birth:
Parent/Guardian Name(s):
Phone Number: Email:

Referring Physician Information

Referring Physician (please print):
Practice/Clinic Name:
Address:
Phone: Fax:

Referral For (select one)



Physical Therapy
Evaluation and Treatment



Occupational Therapy
Evaluation and Treatment

Physical Therapy Referral Reasons

- ☐ Gross motor delay
- ☐ Difficulty walking / gait abnormality / toe walking
- ☐ Balance or coordination concerns
- ☐ Muscle weakness (please specify):
- ☐ Torticollis / plagiocephaly
- ☐ Developmental delay
- ☐ Neurological condition (please specify):
- ☐ Genetic condition (please specify):
- ☐ Other (please specify):

Occupational Therapy Referral Reasons

- ☐ Fine motor delay
- ☐ Handwriting difficulties
- ☐ Feeding difficulties (oral motor / sensory)
- ☐ Sensory processing difficulties
- ☐ Self-care / activities of daily living (dressing, toileting, etc.)
- ☐ Visual motor / visual perceptual skills
- ☐ Developmental delay
- ☐ Neurological condition (please specify):
- ☐ Genetic condition (please specify):
- ☐ Other (please specify):

Additional Information

Diagnosis (ICD-10 code): Precautions / Contraindications:
Relevant Medical History:

Insurance Information

Primary Insurance: Policy/Member ID #:
Secondary Insurance (if applicable): Policy/Member ID #:

Physician Signature (Required)

Physician Signature: Date: