BIG BLUE CANOPY

PEDIATRIC GYM & THERAPY SERVICES

Physical Therapy Occupational Therapy Speech Therapy

FAX REFERRAL FORM / PRESCRIPTION

PATIENT NAME: _____

DATE OF BIRTH: _____

GUARDIAN: _____

PHONE NUMBER: _____

REASON FOR REFERRAL:
☐ OT - Evaluate and Treat
☐ PT - Evaluate and Treat
☐ Speech Therapy - Evaluate and Treat
☐ Orthotics
☐ Assistive Device for Ambulation
☐ Wheelchair Seating Recommendations
☐ Other: _____

MEDICAL DIAGNOSIS:
☐ Known Medical Diagnosis, reason for referral:

_____

PRECAUTIONS:
☐ Infectious Disease: _____
☐ Spinal Instability
☐ Weight Bearing Restrictions: _____
☐ Allergy: _____
☐ Seizure Disorder
☐ Other: _____

***Please attach any relevant testing results (MBS, GI, neurological work-up, nutritionist, etc.)**

PHYSICIAN SIGNATURE:_____DATE:_____

PHYSICIAN NAME (print):_____

PHYSICIAN PRACTICE:_____

PRACTICE PHONE #: _____FAX #:_____

Office notes related to the visit that generated the referral are helpful in scheduling the initial appointment. Please send the demographic sheet along with the referral. Please fax this completed referral to 513-954-0045

11230 CORNELL PARK DRIVE, BLUE ASH, OH 45242 PHONE:513-880-6800 FAX:513-954-0045
EMAIL:INFO@BIGBLUECANOPY.COM WEBSITE: WWW.BIGBLUECANOPY.COM