Connecticut Children's

Date of referral: _____

Clinical Services Order Form

Connecticut Children's Patient Label
For internal use only

FAX: 833.226.2329 or 860.545.9502

Patient Name: (Last) _____ (First) _____
Gender: ☐ M ☐ F **DOB:** _____ **Preferred Language:** _____
Street Address: _____ **City/State/Zip:** _____
Phone: (Preferred): _____ (Secondary) _____
Parent/Guardian/DCF: _____
This visit is: ☐ Routine *Please call 833.733.7669 for all urgent requests.*

Audiology
☐ Evaluation and Treatment ☐ Vestibular and Balance ☐ Sedated Baer ☐ Other
Reason for referral: _____
Contraindications/Precautions/History: _____

Feeding Team ICD10 Code: _____
(Ordering provider acknowledges they are ordering multiple services including Occupational Therapy, Nutrition, and Speech Pathology)
☐ Evaluation ☐ Other
Reason for referral: _____
Contraindications/Precautions/History: _____ Allergies: _____

Nutrition ICD10 Code: _____
☐ Evaluation and Treatment ☐ Other
Reason for referral: _____
Contraindications/Precautions/History: _____ Allergies: _____

Occupational Therapy ICD10 Code: _____
☐ Evaluation and Treatment ☐ Aquatic Therapy ☐ Biofeedback ☐ Feeding ☐ Modalities ☐ Splinting ☐ Other
Reason for referral: _____
Contraindications/Precautions/History: _____

Physical Therapy ICD10 Code: _____
☐ Evaluation and Treatment ☐ Adaptive Equipment ☐ Aquatic Therapy ☐ Biofeedback ☐ Pelvic Floor ☐ Schroth ☐ Other
Reason for referral: _____
Contraindications/Precautions/History: _____

Speech-Language Pathology
☐ Evaluation and 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 Modalities: *Fluoroscopy / X-Ray / CT/ Ultrasound / MRI*
Expected date of exam: _____ Examination Requested: _____
Reason for exam/relevant history: _____
Is sedation required? ☐ Yes ☐ No *Please note: Short History and Physical Form required to schedule sedation.*

Referring Provider: _____ **Phone:** _____ **Fax:** _____

Primary Care Provider: (If different from referring) _____

Is the family aware of this referral? ☐ Yes ☐ No

Signature/Credentials of Provider: _____

*Questions? **Physician practices** call 1.833.733.7669. **Patients** call 860.545.9000.*

Revised October 2019