

**KIDS DEVELOPMENTAL THERAPY  
INTAKE / APPLICATION / REFERRAL FORM**

---

Date of Order \_\_\_\_\_ Patient ID #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Sex: M F

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_

Other Relative: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

---

Services Ordered: PT OT ST Therapists : PT \_\_\_\_\_ OT \_\_\_\_\_ ST \_\_\_\_\_  
Frequency to be determined by therapist and physician after evaluations completed

---

**Diagnosis:**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |
- 

Medical History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

---

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Allergies: \_\_\_\_\_

Referred by: \_\_\_\_\_ at \_\_\_\_\_ Phone: \_\_\_\_\_

---

Primary Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ License #: \_\_\_\_\_

---

Location: \_\_\_\_\_

Other Information: \_\_\_\_\_

Child availability for treatment : \_\_\_\_\_

---

Completed by: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

SOC date: \_\_\_\_\_ To be completed after initiation of Therapy Services