12371 Cottage Woods Drive
Ashland, VA 23005
804.363.7214 (office) 804.798.5279 (fax)

Occupational Therapy Services Referral Form

Medicaid Number ________________________

MR Waiver **DD Waiver**

CSP Year Start date:_______ **CSP Year End date**____________

Review dates: _____ _____ ______ ______

This form is to be completed by the case manager and submitted by fax or email in order to access services.

Child's Name: First__________________ Last________________________ Middle Initial________

Child's Date of Birth ____________ Male _________ Female_________ Social Security # _____________________

Child's Primary Care Physician Name_______________________________ Phone____________________

Diagnosis of child/adult________________________________ Medications__ _____________________________________

____

Allergies ____________________________________ Physician's Name/Phone_____________________________________

Parent or Guardian Name: First________________ Last___________________ Middle Initial______

Parent or Guardian Name: First______________________ Last__________________________ Middle Initial______

Street Address __________________________________ Home Phone_______________________

City, State, Zip __________________________________ Cell Phone_______________

Email ____

If the referral is accepted, the following documents are needed: DMAS-122, CSP, LOF, Psychology and related service reports, behavior plan and any other pertinent documentation to this case.

Reason for Referral/Case manager comments:

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Case Manager Signature ____________________________________ Date _____________________________________

Phone ______________________________ Email___________________________________ Fax: ____________________