CORNERSTONE THERAPY ASSOCIATES

12371 Cottage Woods Drive
Ashland, VA 23005
804.363.7214 (office) 804.442.7027 (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:
_____

_____

_____

Case Manager Signature _____ Date _____
Phone _____ Email_____ Fax: _____