



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.

Individual's Name: First _____ Last _____ Middle Initial _____
Individual's Date of Birth _____ Male _____ Female _____ Social Security # _____
Individual's Primary Care Physician _____ Phone _____
Diagnosis of patient _____ 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: _____