NYU Medical Center **RUSK INSTITUTE** of Rehabilitation Medicine

REFERRAL FOR OUTPATIENT **PEDIATRIC MULTIDISCIPLINARY PATIENTS**

FAX to the RUSK BUSINESS OFFICE (212) 263-0657

Date: _____

Patient Name: _____
Patient Date of Birth: _____ Patient Social Security Number: _____
Caregiver's Name: _____
Telephone Number: Contact 1: (_____)_____-_____
Contact 2: (_____)_____-_____
Patient Address: _____
_____
Primary Insurance: _____ Policy Number: _____ Insured Name: _____
Secondary Insurance: _____ Policy Number: _____ Insured Name: _____

Medical Diagnosis: _____ ***ICD9***: _____
Onset Date: _____

_____ Cerebral Palsy	_____ CVA	_____ TBI
_____ Delayed Physiological Development	_____ Seizure Disorder	_____ Quadriplegia
_____ Spina Bifida w/hydrocephalus	_____ Muscular Dystrophies	_____ Brain Injury
_____ Paraplegia	_____ Spinal muscular atrophy	_____ Amputee
_____ Pervasive Developmental Disorder	_____Ataxia	_____ Neuropathy
_____ Down Syndrome	_____ Brachial Plexus Injury	_____ Encephalitis

_____ Other _____

Prescription for: (Please select all that apply. Include frequency and duration.)

_____ ***Physical Therapy***: ___Evaluation *or* ___Evaluation and Treatment _____ (times/week) _____ (number of months)

_____ ***Occupational Therapy:*** ___Evaluation *or* ___Evaluation and Treatment _____ (times/week) _____ (number of months)

_____ ***Speech and Language***: ___Evaluation *or* ___Evaluation and Treatment _____ (times/week) _____ (number of months)

_____ ***Psychology***: ___Evaluation *or* ___Evaluation and Treatment _____ (times/week) _____ (number of months)

Additional Comments: _____
_____
_____

Physician's Name (Please Print): _____
License Number: _____ UPIN: _____ NPI# _____
Office Telephone: _____ Office Fax: _____

Physician's Signature: _____