OT Solutions
Pediatric Occupational & Speech Therapy

Child Behavioral Therapy Referral Form

Today's Date: _____

Child's Full Name: _____ DOB: _____

Parent/Guardian: _____

Address: _____

Phone: _____ Alternate Phone: _____

Email: _____

Insurance Carrier: _____ Number: _____

Who referred you to OT Solutions Inc.? _____

Name of primary pediatrician: _____

Do you have a referral from your child's pediatrician? YES NO

Has your child been to see a pediatrician in the last 12 months? YES NO

Other medical professionals your child is currently seen by:

_____

_____

Does your child have any medical diagnoses? Please list and when:

_____

_____

_____

1911 S. 17th Street Suite 100 Wilmington, NC 28401 910-313-2111/910-313-2119 fax

Reason for Referral:

__ Attention Issues
__ School Issues
__ Physical aggression
__ Sleep Issues
__ Social skill issues
__ Anxiety
__ Family Issues
__ Self harm
__ Eating Issues
__ Oppositional /Defiant behavior
__ Depression
__ Peer Issues
__ Risky behavior
__ Irritability

Please tell us a little about your child's strengths and accomplishments:

_____

_____

_____

Recent Trauma or Life Events:

_____

_____

_____

Has your child ever received BT in the past? YES NO

When/Where: _____

Does your child attend school? YES NO Where: _____

Does your child have a current IEP? YES NO

Urgency Level: Low Medium High

Additional Comments: _____

_____

_____

Thank you for providing us with this helpful information!!

Referral Source: _____

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