Please **fax** signed referral to Easter Seals Central Texas

A copy of this form, signed by the referring physician, is required for initial evaluation. **If client has Superior Medicaid, *please include authorization from Superior with this form*

Outpatient Rehab

(Comprehensive Outpatient Rehabilitation services for children and adults 3 yrs and older.)

8505 CROSS PARK DR. STE 120, Austin, Texas 78754

Phone: 512.478.2581

Fax: 512.476.1638

(For services for children under 3 yrs, use the State ECI Referral Form or contact Easter Seals ECI at 512.615.6896)

Client Information

Client Name:	DOB:	Sex: ☐M ☐F
Street Address:	City:	Zip:
Parent's Full Name:		
Home Phone:	Work Phone:	

☐Evaluate and Treat ☐ Spanish Speaking ☐ Other Language

Treatment Disciplines (please select): ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Audiology

☐ F84.0 Autistic Disorder	☐ H91.91 Unspecified Hearing Loss, right ear
☐ F84.9 Pervasive Developmental Delay	☐ H91.92 Unspecified Hearing Loss, left ear
☐ F80.81 Childhood Onset Fluency	☐ H91.93 Unspecified Hearing Loss, bilateral
☐ F80.0 Phonological Disorder	☐ R48.1 Agnosia
☐ F80.89 Other developmental disorders	☐ R48.2 Apraxia
☐ F80.9 Developmental Disorder of speech and language, unspecified	☐ R48.8 Other Symbolic Dysfunctions
☐ F90.0 ADHD, predom inattentive type	☐ Q90.0 Trisomy 21 Nonmosaicism
☐ F90.9 ADHD, unspecified type	☐ Q90.1 Trisomy 21 Mosaicism
☐ F90.1 ADHD, predom hyperactive type	☐ Q90.2 Trisomy 21 Translocation
☐ F90.2 ADHD, combined type	☐ Q90.9 Down syndrome, unspecified
☐ F90.8 ADHD, other type	☐ R26.0 Ataxic Gait
☐ F80.2 Mixed receptive-expressive language disorder	☐ R26.1 Paralytic Gait
☐ H93.25 Central Auditory processing disorder	☐ R26.81 Unsteadiness on feet
☐ F82 Specific Development Disorder of motor function	☐ R26.89 Other abnormalities of gait and mobility
☐ G80.9 Cerebral Palsy, unspecified	☐ R26.9 Unspecified abnormalities of gait and mobility
☐ H90.2 Conductive Hearing Loss, unspecified	☐ R62.0 Delayed milestones
☐ H91.90 Unspecified Hearing Loss, unspecified ear	☐ Other

Health Care Provider Information

Ordering Physician:	Primary Care Physician/Practice:	
Address:	Fax:	
Phone:	UPIN #:	NPI #:
Physician Full Name (printed):		

Physician Signature: _____ Date:

****** Note: Physician signature required ******

Form updated: Fall 2015