easterseals
Northeast Central Florida

FAX to 386-258-7677

pediatric specialty clinics

Physician Referral for (Child's Name) ______________________ (M) (F) DOB __________

Parent/Guardian ______________________ Relationship ______________________

Address ______________________ Phone __________

Primary Insurance ______________________ Policy # __________ Group # __________

Subscriber Name ______________________ Subscriber DOB __________

Secondary Insurance ______________________ Policy # __________ Group # __________

☐ Autism Diagnostic and Functional Assessment
includes ADOS-2, Audiology, Occupational, Physical and Speech Therapy Evaluations

☐ PLAY Project (Play and Language for Autistic Youngsters)

☐ Feeding Aversion Therapy
Occupational and Speech Therapy Evaluation and Intervention

☐ Aquatic Therapy

☐ Pediatric Audiology Evaluation

Medical Diagnosis Code: __________ **Treatment Diagnosis Code:** __________

Commonly Used ICD-10 codes:

Lack of Normal Physiological Development ***R62.50***
Unspecified Delay in Development ***F81.9***
Developmental Delay of Speech ***F80.9***
Specific Development Disorder of Motor Function ***F82***

ADHD ***F90.9***
Stereotypical Movement Disorder ***F98.4***
Oppositional Defiant Disorder ***F91.3***
Disruptive Mood Dysregulation Disorder ***F34.8***

Physician Name ______________________ Signature ______________________

Physician Address ______________________

Physician NPI# ______________________ Referral Date __________

Email ______________________ Phone __________ Fax __________

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