Rehabilitative Services/Audiology

Central Scheduling
PH: 937-641-4000 Fax: 937-641-4500
One Children's Plaza • Dayton, OH 45404-1815 • childrensdayton.org

PLEASE PRINT (ALL INFORMATION IS REQUIRED)

Date of Request:_____

PATIENT INFORMATION

Patient's Name:_____

☐ M ☐ F DOB:_____

Parent/Guardian Name(s): _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Preferred Contact Phone: ☐ Work ☐ Cell ☐ Home

Email Address: _____

Patient is in custody of: ☐ Parents ☐ Guardian ☐ CSB

Address: _____

City: _____State: _____ Zip: _____

1st Insurance: _____ ID#: _____

Precert #:_____

2nd Insurance: _____ ID#: _____

Precert #:_____

REFERRING PROVIDER INFORMATION

Office Contact Person: _____

Referring Provider:_____

Phone: _____

Fax:_____

Provider Signature: _____
(required)

Date of Signature: _____

CHECK ONE

☐ Evaluation Only

☐ Evaluation and treatment (if treatment is indicated)

☐ Evaluation and Home Exercise Program

DIAGNOSIS (check *all* that apply)

☐ Autism/PDD ☐ Cerebral Palsy ☐ Cleft Palate ☐ Down Syndrome ☐ Feeding Disorder
☐ Head Trauma ☐ Hearing Loss ☐ Language Deficit ☐ Orthopedic Injury ☐ Speech Impediment
☐ Stuttering ☐ Torticollis ☐ Failed Hearing Screening

☐ Other (please specify): _____

PLEASE SELECT DESIRED SERVICE

OCCUPATIONAL THERAPY

☐ Fine Motor/Developmental
☐ Upper Extremity/Orthopedic (<12 years of age)

Please fax the following to Rehab only at 937-641-5396:

☐ Pressure Garment Measure/Fit
☐ Upper Extremity Splint
☐ Occupational Therapy Evaluation (< 2 years of age)

PHYSICAL THERAPY

☐ Gross Motor/Developmental/Neurologic
☐ Orthopedic Injury/Sports Injury/Back Pain
☐ Torticollis/Plagiocephaly

Please fax the following to Rehab only at 937-641-5396:

☐ Wheelchair Evaluation
☐ Evaluation Crutch Training Only
☐ Lower Extremity Splint

SPEECH THERAPY

☐ Speech/Language Eval **with** Hearing Screen
☐ Speech/Language Eval **without** Hearing Screen
☐ Augmentative Communication (ie, computerized device)
☐ Feeding Evaluation
☐ Voice Clinic (includes SLP and APENT evaluations)
☐ Other (please specify): _____

AUDIOLOGY

☐ Unsedated ABR (Typically for infants <5 months of age)
☐ ABR/OAE test with physician consult for sedation (or behavioral test if appropriate)
☐ Basic eval with two audiologists (children with developmental disabilities or age 3 and under)
☐ Basic hearing evaluation (>4 years of age)
☐ Infant hearing screening (AABR/OAE) **age 0-5 mo**
☐ Other (please specify): _____

Our goal is to process referrals within two business days. If unable to contact family within one week, we will notify your office.

Central Scheduling Notes:

Dayton Children's use only:

Appt. Sched: _____
Date: _____Time: _____
Spoke With: ☐ Mother ☐ Father ☐ Guardian