ADVANCE KIDS IN MOTION OT, PLLC

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Initial Referral Form

Student:	Date:	DOB:	Age:	Grade:
Address:		Pediatrician:		
Allergies:	Special Alerts:			
Parents Names:	Caregiver:	Other:		
Home Phone:	Cell Phone:	Work Phone:		
Email:	Who is responsible for payment?			

Pregnancy and birth history (anything remarkable): ________________________Vaginal or Cesarean (circle one)

How was the pregnancy? How was the birth? ____

NICU Stay? Yes or No, If yes, how long and explain any interventions taken in the NICU?

____

____

Gestational Period (weeks) ______ Birth Weight _____ If C-section why: ______________________________

Diagnoses/Conditions/Allergies/Seizures/Asthma:____

Developmental milestones: Sitting up: ______Crawling: ________ Walking:______ Talking: ________

Hospitalizations/Surgeries: ____

When was Hearing Tested/Vision Tested last and Results:

____

General Health of your child? ____

Has your child seen any specialists? ____

Occupational Therapy Concerns

PRIMARY CONCERN # 1 ____

PRIMARY CONCERN # 2 ____

PRIMARY CONCERN # 3 ____

ADDITIONAL CONCERNS ____

Referred by: ____

I give permission for my child to have an Occupational Therapy Evaluation by Stephanie Bronstein. I understand that all information will be kept confidential unless I fill out a consent form so that Stephanie Bronstein can discuss/provide written copies of my child's progress with the Pediatrician, other doctors, teachers, or other therapists.

______________________________ ________________

Parent's Signature **Date**