NYU Langone Health

RUSK REHABILITATION

REFERRAL FOR OUTPATIENT **PEDIATRIC PHYSICAL THERAPY**

FAX to RUSK REHABILITATION • 212.263.4555

Date:_____

Patient Name: _____ Sex: M □ F □

Patient Date of Birth

Parent/Guardian Name (if appropriate): _____

Patient/Guardian Telephone Number: Contact 1: (_____) _____ - _____

Contact 2: (_____) _____ - _____

Patient Address: _____

_____

Primary Insurance:_____ Policy Number:_____ Insured Name:_____

Secondary Insurance:_____ Policy Number:_____ Insured Name:_____

***Medical Diagnosis*:** _____ ***ICD 10*:**_____

_____Cerebral Palsy	_____CVA	_____TBI
_____Hypotonia	_____Seizure Disorder	_____Muscular Dystrophies
_____Spina Bifida W/Hydrocephalus	_____Torticollis	_____Quadriplegia
_____Paraplegia	_____Spinal Muscular Atrophy	_____Gait Disorders
_____Ataxia	_____Neuropathy	_____Amputee
_____Brachial Plexus Injury	_____Encephalitis	_____Down Syndrome

_____Other _____

***Onset Date*:** _____

Prescription for : (Please select)

_____PT Pediatric Evaluation	_____Therapeutic Exercise
_____Orthotic Evaluation and Fabrication	_____Manual Therapy
_____Neuro Re-Education	_____Gait Training
_____FES Evaluation (Bioness, FES Bike)	_____Serial Casting Program
_____Robotic Gait Training Intensive	_____Aquatic Therapy Intensive
_____Concussion/Vestibular Treatment	_____Equipment Evaluation (Stander, Walker, Adaptive Bike)

***Physician Order Frequency and Duration*:** _____ _____

(Times/week) **(numbers of months)**

Physician's Name (Please Print): _____

License Number: _____ UPIN: _____ NPI# _____

Office Telephone: _____ Office Fax: _____

Physician's Signature: _____

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