Washington University in St. Louis
School of Medicine

Occupational Therapy

COMMUNITY PRACTICE REFERRAL FORM

Adult Services

Fax completed form to: (314) 289-6131

Patient Information

Patient Name					
Date of Birth					
Address					
City		State		ZIP	
Phone Number					
Alternate Phone					
Alternate Contact (name)					
Alternate Contact (phone)					

Note: Please attach a copy of the patient's insurance card, both front and back, with this referral form.

Physician/Referring Agency Information

Referring Agency Contact					
Physician Name					
Address					
City		State		ZIP	
Phone number					
Fax number					
Email address					

Preferred Therapist/Additional Comments:

Adult Services for OT/PT evaluation and treatment

	General OT (clinic, in-home or home modifications)
	Adolescent Substance Abuse
	Cancer Survivorship
	CBIT
	Community Accessibility
	Hand Therapy
	Healthy Aging
	Low Vision
	Movement Disorders
	Occupational Performance
	Parenting with Disabilities
	Seating, Mobility and Assistive Technology

Reason for Referral/Medical History

Please use the space below to specify reason for referral.

Diagnosis	
ICD Code(s)	

Physician Signature		Date	

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