CookChildren's.

Rehabilitation Services referral form

For ongoing therapy, **fax updated order to 682-885-7590**. Please attached face sheet/insurance sheet to referral.
Please instruct families to call for appointment scheduling. Rehabilitation new patient **scheduling line is 682-885-3898**.

For this order to be processed, please fill out all fields.

Patient name: ______________________ DOB: ______________ Sex: ____________

Diagnosis: ______________________________ ICD-10 code(s): ______________

Service requested: (please indicate) ○ **PT** ○ **OT** ○ **ST** ○ **AUDIO**

Priority: ○ **Routine** (within 12 weeks) ○ **High** (within two weeks) ○ **Stat** (within 24 hours)

Physician order: (check all services that apply)

Physical therapy

○ Evaluate and treat
○ Other

____

Pelvic floor therapy

○ Evaluate and treat

Occupational therapy

○ Evaluate and treat
○ Other

____

Speech/Language pathology

○ Evaluate and treat
○ Feeding/oral motor evaluate and treat
○ Swallow function study
○ Soft palate study
○ Nasopharyngoscopy
○ Other

____

Audiology

○ Audiology evaluation and management
○ ABR (sedated)
○ ABR (unsedated)
○ Hearing aid evaluation
○ Cochlear implant evaluation
○ Vestibular evaluation
○ Other

____

Date of onset/procedure/surgery: ______________________

Precautions: ____
(Brace requirements, ROM limitations, weight bearing, incision care, fall precautions, allergies, active drainage, etc.)

____
Physician signature Date/time

____
Physician name (printed) Physician phone Fax

Special instructions/comments: ____

____

____
Contact person at office Phone

Rehabilitation locations:
Fort Worth, Hurst, Mansfield and Walsh

03.2026