Cove
Child
Development
Hawaii Occupational Therapy

Fax Referral Form

This referral form authorizes Cove Child Development to evaluate and treat (if indicated) the recipient listed below

Patient Name: _____ **Date of Birth:** _____

Guardian: _____ **Phone number**: _____

Concerns:_____

_____

MEDICAL DIAGNOSIS:

☐ ADD (F90.0)
☐ ADHD (F90.1)
☐ Angelman Syndrome (Q93.51)
☐ Apraxia (R48.2)
☐ Arthrogryposis (Q74.3)
☐ Asperger Syndrome (F84.5)
☐ Autism (F84.0)
☐ Cerebral Infarction, Unspecified (I63.9)
☐ Central Auditory Processing Disorder (H93.25)
☐ Cerebral Palsy, Unspecified (G80.9)
☐ Chondromalacia (M94.20)
☐ Craniosynostosis (Q75.0)
☐ Disorder of CNS, Unspecified (G96.9)
☐ Down Syndrome (Q90.9)
☐ Ehler's-Danos Syndrome, Unspecified (Q79.60)
☐ Encephalopathy, Unspecified (G93.40)
☐ Epilepsy, Unspecified (G40.9 series)
☐ Erb's Palsy, Monoplegia (G83.23)
☐ Fracture
☐ Fragile X (Q99.2)
☐ Hemiplegia unspecified (G81.90)
☐ Hydrocephalus, Arnold Chiari Malformation (Q07.02)
☐ Hydrocephalus, Congenital, Unspecified (Q03.9)
☐ Feeding Difficulties (R63.3)
Height: _____ Weight: _____
☐ Juvenile Rheumatoid Arthritis
☐ Monoplegia (G83.23)
☐ Muscular Dystrophy, Unspecified (G71.00)
☐ Osteogenesis Imperfecta (Q78.0)
☐ Pervasive Developmental Disorder (F84.8)
☐ Premature Birth, Birth Injury-Unspecified (P15.9)
☐ Spina Bifida with Hydrocephalus, Unspecified (Q05.4)
☐ Spina Bifida without Hydrocephalus, Unspecified (Q05.5)
☐ Spinal Cord Injury
☐ Torticollis (M43.6)
☐ Traumatic Brain Injury
☐ Other: _____

PRECAUTIONS:
☐ Infectious Disease: _____
☐ Spinal Instability
☐ Weight Bearing Restrictions: _____
☐ Allergy: _____
☐ Seizure Disorder
☐ Other: _____

***Please attach any relevant testing results (MBS, GI, neurological work-up, nutritionist, etc.)**

PHYSICIAN SIGNATURE:_____DATE:_____

PHYSICIAN NAME (print):_____

PHYSICIAN PRACTICE:_____

PRACTICE PHONE #:_____FAX #:_____

FAX REFERRAL TO:
808-707-8237