



# Physical Therapy & Occupational Therapy New Patient Referral Requirements

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**ChildrensHospitalLosAngeles**

*International Leader in Pediatrics*

Please complete and fax to the number above. Thank you!

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

## **ADDITIONAL REFERRAL INFORMATION REQUIRED**

**\*Delays in obtaining documentation will delay appointment scheduling\***

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### **I. CHLA "NEW PATIENT REFERRAL FORM - ALL CLINICS" MUST BE COMPLETED**

### **II. ADDITIONAL PATIENT INFORMATION - NONE REQUESTED**

### **III. CLINICAL DOCUMENTATION REQUESTED**

\_\_\_ **Medical Notes**

\_\_\_ **Signed Prescription**

### **IV. AUTHORIZATION REQUESTED (If non-PPO Patient):**

#### Physical Therapy:

\_\_\_ 97001 - Physical Therapy Evaluation

\_\_\_ 97110 - Physical Therapy Treatment (X number of visits)

#### Hydrotherapy:

\_\_\_ 97022 - Whirlpool (X number of visits)

\_\_\_ 97001 - with Physical Therapy Evaluation

\_\_\_ 97597 - with selective debridement  $\leq$  20 square centimeters (X number of visits)

or \_\_\_ 97597 - with selective debridement  $>$  20 square centimeters (X number of visits)

or \_\_\_ 97602 - with non-selective debridement (X number of visits)

#### Occupational Therapy:

\_\_\_ 97003 - Occupational Therapy Evaluation

\_\_\_ 97110 - Occupational Therapy Treatment (X number of visits)

#### Feeding/Dysphagia Team

\_\_\_ 92610 - Feeding/Swallowing Evaluation

\_\_\_ 92611 - Modified Barium Swallow Study (MBSS) with OT or ST

74230 - with Radiology/Fluoroscopy Exam