Scheduled Time: ____ **Date of Referral:** ___________________
Therapist Assigned: ____________________________________ **Home Services**☐ **Center Services**☐

Kennedy Krieger Institute
Child & Family Support Program
1750 E. Fairmount Avenue
Baltimore, MD 21231
Referral Line: 443-923-3285 Fax:443-923-3845

CHILD REFERRAL FORM OT/PT/SLP SERVICES

DATE: ________________________________

CHILD INFORMATION:

Child Name: **DOB:**

Index #: **KKI #:** **SS#:**

Sex: **Race:** **Diagnosis:**

MA #: **MCO:**

REFERRAL INFORMATION:

Name: **Phone#:** **Fax #:** **E-mail:**

Address: **Reason for referral:**

FAMILY INFORMATION:

Parent Name/Guardian Name:

Address:

City: **Zip:**

Phone (1): **Phone (2):**

INSURANCE INFORMATION:

Insurance Co. **(Primary):** **Policy #:**

Policy Holder's Name: **Group#:**

Secondary Insurance:

SERVICE REQUESTED

			CENTER BASED		HOME BASED
DISCIPLINE		***No. Sessions/Frequency***	***Intensity***		***Intensity***
☐ **OT** ○ fine motor ○ sensory	☐ **Eval.**		☐ **30 Min.**	☐ **60 Min.**	☐ **60 Min.**
☐ **PT**	☐ **Eval.**		☐ **30 Min.**	☐ **60 Min.**	☐ **60 Min.**
☐ **SLP**	☐ **Eval.**		☐ **30 Min.**	☐ **60 Min.**	☐ **60 Min.**

Transportation Needed: □ **yes** □ **no**

Service Coordinator: **IFSP valid:** ***from*** ***to***

Location of Services(if different from home):

Contact person's name: **Telephone #:**

Best days/Times for Services:

SERVICE PROVIDERS:

PCP: **Address:**	**Phone:** **Fax:**
Physician (other MDs):	**Phone:**
Other Providers:	**Phone:** **Email:**
	Phone: **Email:**
	Phone: **Email:**