# Summit Sprouts Therapy, LLC.

Patient Name:_____ DOB:_____
Medicaid #:_____

Contact Name:_____ Phone:_____

Commonly Used ICD-10 Codes

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|---|---|
| ☐ | F82-SPECIFIC DEVELOPMENTAL DISORDER OF MOTOR FUNCTION |
| ☐ | F909-ATTENTION-DEFICIT HYPERACTIVITY DISORDER, UNSPECIFIED TYPE |
| ☐ | F84-PERVASIVE DEVELOPMENTAL DISORDERS |
| ☐ | F840-AUTISTIC DISORDER |
| ☐ | R27-OTHER LACK OF COORDINATION |
| ☐ | M6281-MUSCLE WEAKNESS (GENERALIZED) |
| ☐ | M256-STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED |
| ☐ | Other: |

Conditions Commonly Associated with Treatment of Pediatric Patients

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|---|---|
| ☐ | R62-LACK OF EXPECTED NORMAL PHYSIOL DEV IN CHILDHOOD AND ADULTS |
| ☐ | R620-DELAYED MILESTONE IN CHILDHOOD |
| ☐ | R625-OTH AND UNSP LACK OF EXPECTED NORMAL PHYSIOL DEV IN CHLDHD |
| ☐ | R6251-FAILURE TO THRIVE (CHILD) |
| ☐ | R633-FEEDING DIFFICULTIES |
| ☐ | Other: |

## *Physician Signature & Referral*

____ OT Evaluation / Treatment for ____ (#) sessions. OT Evaluation Only ____

Physician's Signature:_____ Date:_____
Physician's Printed Name:_____ NPI#:_____

***When signed by a physician, this form acts as a prescription for therapy services. Please return this form along with any additional relevant medical information to Summit Sprouts Therapy, LLC.***