

# Summit Sprouts Therapy, LLC.

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_

## Commonly Used ICD-10 Codes

<input type="checkbox"/>	F82-SPECIFIC DEVELOPMENTAL DISORDER OF MOTOR FUNCTION
<input type="checkbox"/>	F909-ATTENTION-DEFICIT HYPERACTIVITY DISORDER, UNSPECIFIED TYPE
<input type="checkbox"/>	F84-PERVASIVE DEVELOPMENTAL DISORDERS
<input type="checkbox"/>	F840-AUTISTIC DISORDER
<input type="checkbox"/>	R27-OTHER LACK OF COORDINATION
<input type="checkbox"/>	M6281-MUSCLE WEAKNESS (GENERALIZED)
<input type="checkbox"/>	M256-STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED
<input type="checkbox"/>	Other: _____

## Conditions Commonly Associated with Treatment of Pediatric Patients

<input type="checkbox"/>	R62-LACK OF EXPECTED NORMAL PHYSIOL DEV IN CHILDHOOD AND ADULTS
<input type="checkbox"/>	R620-DELAYED MILESTONE IN CHILDHOOD
<input type="checkbox"/>	R625-OTH AND UNSP LACK OF EXPECTED NORMAL PHYSIOL DEV IN CHLDHHD
<input type="checkbox"/>	R6251-FAILURE TO THRIVE (CHILD)
<input type="checkbox"/>	R633-FEEDING DIFFICULTIES
<input type="checkbox"/>	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.***