Integrative Wellness Solutions

7076 Oak Hill Road
Loudon, N.H. 03307
(603) 417-4847
www.integrativewellnesssolutions.net

Occupational Therapy Doctor's Order

Client's Name:	Parent/Guardian (if applicable):
Date of Birth:	Phone Number:

Services Requested (Check all that apply)

☐ OT Evaluation	☐ OT Treatment

Diagnosis (ICD 10)

☐	F41.1- Generalized Anxiety Disorder	☐	R20.8 - Other disturbances of skin sensation
☐	F82 - Specific developmental disorder of motor function	☐	R27.8- Other lack of coordination
☐	F84.0-Autistic Disorder	☐	R41.840 - Attention and concentration deficit
☐	F84.5- Asperger's Syndrome	☐	R41.842- Cognitive deficit, visuospatial deficit
☐	F84.8- Other Pervasive Developmental Disorder	☐	R41.844- Cognitive deficit, frontal lobe & executive function
☐	F90.0 - ADHD, inattentive type	☐	R43.8- Other disturbance of smell & taste
☐	F90.1 - ADHD, hyperactive type	☐	R44.8- Other symptoms & signs involving general sensations & perception
☐	F90.2 - ADHD, combined type	☐	R45.82- Worries
☐	F91.0- Conduct Disorder, Confined to family	☐	R45.87- Impulsiveness
☐	F91.1- Conduct Disorder, childhood onset type	☐	R46.0- Low level of personal hygiene
☐	F91.2- Conduct Disorder, adolescent onset type	☐	R46.81- Obsessive compulsive behaviors
☐	F91.3- Oppositional Defiant Disorder	☐	R62.0- Delayed milestones in childhood
☐	F94.1- Reactive attachment disorder	☐	R62.50- Other lack of expected normal physiological development in childhood
☐	F94.8- Other Childhood disorder of social function	☐	Other: _____

I hereby determine that the services listed above are medically necessary.

Physician signature: _____ Date: _____

Name (print): _____ NPI #: _____

Address: _____ Phone #: _____

_____

Integrative Wellness Solutions

7076 Oak Hill Road
Loudon, N.H. 03307
(603) 417-4847
www.integrativewellnesssolutions.net

Insurance Referral Request

Client Name:	Date of Birth:
Insurance Company:	Insurance ID#
Physician:	Diagnosis (ICD10 code):

Referral Information

Services Requested: _____ Occupational Therapy	Number of visits requested: _____
Dates of service requested: From: _____ To: _____	
If you require additional information to complete this request, please contact us via the contact information above. Thank you for your time and attention.	
Physician signature:	Date:
Printed name:	NPI #:
Address:	Phone #: