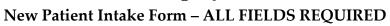


The Children's TherAplay Foundation, Inc.





Date: How did you hear	about Childrer	n's TherAplay?		
Referral for: □ Physical Therapy □ Occupa	tional Therapy	py □ Speech Therapy		
Patient Name:	DOB:	DOB: Ethnicity/Race: □Pr		
Diagnosis:				
Can patient sit independently? □Yes □No How much assistance is required for transfers? □ How long can your child hold their head up while	Min (25% help) 🗆	Mod (50% help) □ Max (75% help) □ Total Assist	(100% help)	
Does your child have any of the following health conditions?:				
Atlanto-axial instability with neurological signs as assessed by MD	□Yes □No	Mental health conditions that place the patient or others at significant safety risk (e.g., severely aggressive behaviors, frequent hitting, biting, throwing, scratching, screaming, or elopement)	□Yes □No	
Chiari malformation with neurological symptoms	□Yes □No	Coxa Arthrosis	□Yes □No	
Seizures or unstable neurological system uncontrolled by medication	□Yes □No	Hemophilia with recent history of bleeding episodes	□Yes □No	
Indwelling urethral catheters	□Yes □No	Medical conditions during acute exacerbations (e.g., asthma flare ups, seizures, etc.)	□Yes □No	
Open wounds over a weightbearing surface	□Yes □No	Pathological fractures without successful treatment of the underlying pathology	□Yes □No	
Acute fractures	□Yes □No	Tethered cord syndrome with symptoms	□Yes □No	
Unstable spine and/or internal hardware of fixation/fusion	□Yes □No	Difficulties with being touched/handled during transfers or daily activities	□Yes □No	
What therapies does patient currently receive?Location: Date of last PT/OT/ST evaluation:Location:				
Preferred Times for therapy appointments: (please I Monday I Tuesday I Wednesday I Family Goals for Patient:	-			
Parent/Guardians:				
Address:				
City, State, Zip:				
Home Phone: Call:		F-mail:	-	

Referring Physician:			
Physician's Medical Group:			
Physician's Address:			
	MD Fax:		
Referring Therapist:	Phone:		
Insurance: Please check ALL that	apply		
□ Medicaid □ Children's S	Special Health Care Services	□ Private Insurance	
Medicaid Case Manager:	Phone:	Fax:	
Type of MCD: □ Traditional	□ Waiver □ Risk Based Managed Care		
Client's RID #:	Effective Date:		
CSHCS: ID #:	Effective Date:		
Private Insurance:			
Company:			
	DOB:		
Policy#	Group #		
Provider Services Phone Number	(on back of card)		

Communication Permissions

Appointment reminders and treatment follow-up messages may be sent via cell phone SMS texting. It is your right to decline communication of this nature for any reason.

I would like to opt out of texts

Please be sure to inform us of ANY changes in your insurance. Failure to do so may result in patient responsibility for the entire billable amount.

Please return this form to Kaylin Shiver at kshiver@childrenstheraplay.org.

9919 Towne Road • Carmel, Indiana 46032 • Phone: (317) 872-4166 • Fax: (317) 872-3234 • www.childrenstheraplay.org

What does a "float" schedule mean?

It can often be hard to some families to schedule and keep weekly reoccurring appointments. We realize that families have a lot going on. "Float scheduling" provides families the flexibility they may need. It allows the family to tell Children's TherAplay (CTF) what time works for them each week. This may change as often as the family needs it to and is scheduled by the parent one week prior to the next appointment. These appointments can be made by phone or at the check-out desk following each appointment.