WMU Unified Clinics
Resiliency Center for Families and Children

Patient Name: ______________________________________ **DOB:** _____/_____/_____
Address: ________________________________ **Phone:** _________________________

Referring Physician: ____
Name of Practice: ____
Phone:_____-_____-___________ **Fax:** _____-_____-_____________

Date of last physical: _____/_____/_____

Please include a copy of the patient's most recent history and physical.

Please Address:

Diagnosis and ICD-10 Code:
____
____
____
____

OT Eval and Treat

With my signature, I authorize the above individual for outpatient occupational therapy evaluation and treatment.

Physician's Signature: _________________________________ **Date:** _____/_____/_____
Printed Name: _______________________________________

Thank you for this referral!

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