EAST TENNESSEE Children's Hospital

**Pediatric Physiatry**
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# Physiatry Referral Request

**Please send the following information along with the referral form**

- ☐ Completed referral form
- ☐ Physician's last office visit
- ☐ Demographics
- ☐ Insurance cards (copy front and back)
- ☐ Insurance authorization (if required)
- ☐ Medication list
- ☐ Pertinent test results
- ☐ Guardianship papers

**Has this patient been seen by another Physiatrist?** ☐ **Yes** ☐ **No**
If yes: Physiatrist name: _____ Date last seen: _____

Referring physician: _____ Date: _____
Office phone: _____ Contact person: _____
Patient's name: _____ Date of Birth: _____
Patient's SSN: _____ Gender: ☐Male ☐Female
Language preferred: _____
Address: _____ Hearing impaired ☐Yes ☐No
City: _____ Zip Code: _____
Primary insurance: _____
Secondary insurance: _____

***Guardian must bring proof of guardianship to the appointment***

Mother/guardian's name: _____ Home phone: _____
Mother/guardian's SSN: _____
Cell phone: _____ Work phone: _____
Father/guardian's name: _____ Home phone: _____
Father/guardian's SSN: _____
Cell phone: _____ Work phone: _____

**Reason for referral (please mark all that apply)**

- ☐ Acquired brain injury
- ☐ Cerebrovascular accident
- ☐ Gait abnormalities
- ☐ Prematurity
- ☐ Spinal cord injury
- ☐ Amputation
- ☐ Cerebral Palsy
- ☐ Muscular Dystrophy
- ☐ Multiple Sclerosis
- ☐ Peripheral nerve injury
- ☐ Spasticity
- ☐ Spina Bifida
- ☐ Torticollis
- ☐ Wheelchair equipment management
- ☐ Neuromuscular disease arthrogryposis
- ☐ Other: _____