EAST TENNESSEE Children's Hospital

Rehabilitation Services

Physician Referral

Child's name:_____ DOB:_____Gender:_____

Child's SSN#:_____Interpreter:_____Language:_____

Parent/guardian:_____Phone: ( )_____

DCS caseworker:_____County:_____Phone: ( )_____

Address:_____

Street City State Zip

Insurance:_____ Authorization:_____

MEDICALLY RELATED DIAGNOSIS:_____ ICD-10:_____

Services Requested

Please check service type requested

___Speech/language evaluation & treatment

___Physical therapy evaluation & treatment

___Oral motor/feeding therapy evaluation & treatment

___Occupational therapy evaluation & treatment

Therapy restrictions or comments:_____

Physician signature:_____Date:_____

Print physician name:_____Phone number:_____

Physician to follow care:_____

*****Complete information will promote timely scheduling. Thank you.*****

Please indicate the location of preference for patient/family below

Return by Fax to: (865) 693-3941

☐ **Downtown**
Medical Office Building,
Suite 130
2100 Clinch Avenue
Knoxville, TN 37916
Ph: (865) 541-8652

☐ **North Knoxville**
Emory Center
207 E. Emory Road
Powell, TN 37849
Ph: (865) 343-6983

☐ **Sevierville**
Sevier Outpatient Center
502 Winfield Dunn Pkwy.
Sevierville, TN 37876
Ph: (865) 280-6526

☐ **West Knoxville**
Rehabilitation Center
1025 Children's Way
Knoxville, TN 37922
Ph: (865) 690-8961

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