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

☐ **Emory Center**
207 E. Emory Road
Powell, TN 37849
Ph: 865.343.6983

☐ **Sevier Outpatient Center**
502 Winfield Dunn Pkwy.
Sevierville, TN 37876
Ph: 865.280.6526

☐ **Rehabilitation Center**
1025 Children's Way
Knoxville, TN 37922
Ph: 865.690.8961

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