EAST TENNESSEE Children's Hospital

Rehabilitation Services

Motivating Mealtimes 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

_x_ **Motivating Mealtimes Evaluation,**

which will include:

- Oral Motor/Feeding Therapy Evaluation and Treatment
- Occupational Therapy Evaluation and Treatment
- Medical Nutrition Therapy Evaluation and Treatment
- Behavioral Health Evaluation and Treatment

Comment(s): _____

_____

_____

_____

_____

_____

Physician signature:_____ Date:_____

Print physician name: _____

Office contact phone number: _____

Return by fax to: (865) 693-3941

Return by email to: motivatingmealtimes@etch.com

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