WESTERN MICHIGAN UNIVERSITY
College of Health and Human Services
Resiliency Center for
Families and Children

Resiliency Center for Families and Children
Western Michigan University
Unified Clinics
1000 Oakland Dr.
Kalamazoo, MI 49008
Phone: (269) 387-7004
Fax: (269) 387-7026

Occupational Therapy Referral Form

Thank you for your interest in making a referral on behalf of a child to receive Occupational Therapy through the Resiliency Center. Please, fill out this referral form out completely and return to the email that you received the referral.

Occupational Therapy requested

OT - Parent Coaching_____ Outpatient OT Therapy_____

Trust Based Relational Intervention_____

Intake Information

Name of Child:_____ Today's Date:_____

Date of Birth:_____ Child's age:_____

Gender: ☐ Male ☐ Female ☐ Another Gender:_____

Race: (if multiracial please check all that apply)

☐ American Indian

☐ Asian

☐ Black / African American

☐ Another Race

☐ Hispanic

☐ Native Hawaiian / Pacific Islander

☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Primary language spoken at home: _____

Caregiver Information/Emergency Contact

Name:_____ Relationship to child: _____

Address: _____

Phone:_____ Email:_____

Contact Information of Referring Person

Referring Person: _____

Agency:_____

Address: _____

Phone:_____ Email: _____

Insurance

Insurance Name/Company_____

Member ID # _____

Group #_____

Subscriber Name and Date of Birth _____

Claim information on the back of card _____

What are the current custody arraignments for the child?

☐Full custody

☐Joint legal, full physical custody

☐Joint legal and physical custody

☐Guardianship

☐Adopted

☐Other – please explain: _____

By the end of this course of treatment, what would you like to achieve?

Child(ren) Information

Number of Children in the Home: _____

Child's Name	Birth Date	Current Age	Gender
Click or tap here to enter text.	##	##	Click or tap here to enter text.
Click or tap here to enter text.	##	##	Click or tap here to enter text.
Click or tap here to enter text.	##	##	Click or tap here to enter text.
Click or tap here to enter text.	##	##	Click or tap here to enter text.
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Click or tap here to enter text.	##	##	Click or tap here to enter text.

WMU Unified Clinics

Resiliency Center for Families and Children

Patient Referral

Patient Name: _____ **DOB:** _____/_____/_____

Address: _____ **Phone:** _____

Referring Physician: _____

Name of Practice: _____

Phone:_____-_____-_____ **Fax:** _____-_____-_____

Date of last physical: _____/_____/_____

A summery of the client's last office visit or clinical services should be included with the occupational therapy script. Referral information can be faxed to the WMU Resiliency Center 269-387-7026 or emailed to chhs-rcat@ wmich.edu.

Please Address:

Diagnosis and ICD-10 Code:

OT Evaluation and Treatment

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

Physician's Signature: _____ **Date:** _____/_____/_____

Printed Name: _____

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