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) 387-7073
Fax: (269) 293-3357
E-mail: chhs-rcat@wmich.edu

Occupational Therapy Referral Form

To schedule Occupational Therapy services, we require the attached document to be completed and submitted back to our office. ***The last page (OT script page) will need to be completed and faxed or emailed back by your child's physician, *along with a last visit summary. This is required for all insurance referrals, we cannot schedule for services until all required information is received from the physician. This information can be faxed to (269)293-3357 or emailed to chhs-rcat@wmich.edu.***

Occupational Therapy requested

OT - Parent Coaching: _____ Outpatient OT Therapy: _____

Child's Name: _____

Preferred Name: _____ **Date of Birth:** _____ **Age:** _____

We care about understanding who you are. If you don't see yourself reflected in the categories provided below, please use the text boxes to write in your answer

Sex assigned at birth: ☐ Male ☐ Female ☐ Intersex

Gender Identity: ☐ Male ☐ Female ☐ Non-binary / Gender Nonconforming
☐ Questioning / Not sure ☐ Prefer not to say
☐ Not listed. Please describe: _____

Ethnicity: ☐ Hispanic or Latino/a ☐ non-Hispanic or Latino/a

Race: (if multiracial please check all that apply)

☐ American Indian or Alaska Native ☐ White / Caucasian
☐ Asian ☐ Native Hawaiian / Pacific Islander
☐ Black or African American ☐ Prefer not to say
☐ Another Race Not Listed. Please describe: _____

Primary language(s) spoken in the home:

☐ English ☐ Other Language(s). Please describe: _____

Primary Caregiver(s) Information

Name(s): _____

Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email Address: _____

Additional Caregiver(s) Information

Name(s): _____

Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email Address: _____

Contact Information of Referring Person

Referring Person: _____

Agency: _____

Phone Number: _____

Email Address: _____

What are the current custody arrangements for the child?

☐ Full custody ☐ Joint legal, full physical custody ☐ Joint legal and physical custody

☐ Foster Care ☐ Guardianship ☐ Kinship Care

☐ Other – please explain: _____

Primary OT Concerns (Check all that apply):

Handwriting/Fine Motor Skills	
Sensory Processing/Regulation	
Social Skills	
Self-Care/Independence in Daily Routines	
Strength and Coordination	
Feeding/Oral Motor Skills	

Medical Information

Does the child have a Primary Care Provider? ☐Yes ☐ No

Provider's Name**:** _____

Provider's Practice: _____

Provider's Phone Number: _____

Are there any medical concerns or diagnoses for the child? ☐Yes ☐ No

If yes, please explain: _____

Is the child currently taking any medications? ☐Yes ☐ No

If yes, please list the medications and the dosages:

Medication Name	Dosage

Insurance Information

Insurance Name/Company: _____

Member ID #: _____

Group #: _____

Subscriber Name and Date of Birth: _____

Relationship to Child: _____

Claim information phone number on the back of card: _____

Additional Information

What school does the child attend? _____

Does the child have an IEP or 504 plan? ☐Yes ☐ No

Are there other children in the home? ☐Yes ☐ No

If yes, please complete the following section:

Other Children's Names	Age	Gender	Relationship to Client

Does the child currently receive additional services (Early On, Special Education, speech and language services)? ☐Yes ☐ No

If yes, please list services and providers of the child: _____
_____

Is there any additional information that you would like the Resiliency Center to know?

To learn more about additional services offered by the WMU Resiliency Center please contact our main office at 269-387-7073 or visit our website at wmich.edu/unifiedclinics/resiliencycenter.

Please complete the attached Trauma Symptom Checklist (Henry, Black-Pond & Richardson, 2010) by marking known or suspected trauma exposure, as well as other concerns the child may present with. For children 0-5 years old, please complete the section starting on page 5. For children 6 and up, please complete the section starting on page 6:

Children 0-5:

Known or Suspected Trauma Exposure:			
	Physical abuse		Exposure to drug activity (aside from parental use)
	Neglectful home environment		Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy
	Emotional abuse		Lengthy or multiple separations from parent
	Exposure to domestic violence		Placement outside of the home (kinship care, foster care, residential)
	Exposure to other chronic violence		Loss of significant people, places, etc.
	Sexual abuse or exposure		Frequent/multiple moves; homelessness
	Parental substance abuse		Other:
	Impaired parenting (mental illness)		

Behavioral Signs of Trauma:			
	Aggression towards self; self-harm		Sexual behaviors not typical for age
	Excessive aggression or violence towards others		Difficulty sleeping, eating, or toileting
	Explosive behavior (going form 0-100 instantly)		Social/developmental delays in comparison to peers
	Hyperactivity, distractibility, inattention		Repetitive violent and/or sexual play (or maltreatment themes)
	Excessively shy		Unpredictable/sudden changes in behavior (i.e., attention, play)
	Oppositional and/or defiant behavior		Other:

Emotional Signs of Trauma:			
	Excessive mood swings		Flat affect, very withdrawn, seems emotionally numb or “zoned out”
	Frequent, intense anger		Other:
	Chronic sadness, doesn’t seem to enjoy any activities, depressed mood		

Relational/Attachment Difficulties:			
	Lack of eye contact or avoids eye contact		Doesn’t reciprocate when hugged, smiled at, spoken to
	Sad or empty eyed appearance		Doesn’t seek comfort when hurt or frightened; shakes it off, or doesn’t seem to feel it
	Overly friendly with strangers (lack of appropriate stranger anxiety)		Has difficulty in preschool or daycare
	Vacillation between clinginess and disengagement and/or aggression		Other:

Children 6+

Known or Suspected Trauma Exposure:			
	Physical abuse		Exposure to drug activity (aside from parental use)
	Neglectful home environment		Prenatal exposure to alcohol/drugs or maternal stress during pregnancy
	Emotional abuse		Lengthy or multiple separations from a parent
	Exposure to domestic violence		Placement outside of the home (kinship care, foster care, residential)
	Exposure to other chronic violence		Loss of significant people, places, etc.
	Sexual abuse or exposure		Frequent/multiple moves; homelessness
	Parental substance abuse		Other:
	Impaired parenting (mental illness)		

Behavioral Signs of Trauma:			
	Aggression towards self; self-harm		Oppositional/defiant behavior
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	Hyperactivity, distractibility, inattention		Social/developmental delays in comparison to peers
	Excessively shy		Other:

Emotional Signs of Trauma:			
	Excessive mood swings		Flat affect, very withdrawn, seems emotionally numb or “zoned out”
	Frequent, intense anger		Other:
	Chronic sadness, does not seem to enjoy any activities, depressed mood		

Difficulties in School:			
	Low or failing grades		Difficulty with authority/frequent behavior referrals
	Attention and/or memory problems		Other:
	Sudden changes in performance		

Relational/Attachment Difficulties:			
	Lack of eye contact or avoids eye contact		Does not seek adult help when hurt of frightened
	Lack of appropriate boundaries in relationships		Other:

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 269-293-3357 or emailed to chhs-rcat@ wmich.edu.

*Please Add Full Diagnosis and Coding

Diagnosis	**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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