REQUIRED: PLEASE ATTACH CURRENT RECORDS AND / OR REPORTS

Physician's Referral and Prescription for Children's Medical Services: Medical Therapy Services

Please fill in appropriate boxes

Name: ______________________ Birth date: ____________ Primary Care Physician: __________________

Address: ____________________ Phone: ______________ Parent: ____________________________

Date of Exam: _________________ Height: ______________ Weight: __________________________ kg

Current Medications: ____

REQUESTED SERVICES (Fields below are required to process MTP prescription/referral):

Eligible Medical Therapy Diagnosis: ____

Occupational Therapy Evaluation:________ Physical Therapy Evaluation: __________ MTU Conference (Clinic): ____________

N = Normal **A = Abnormal** **I = Increased** **D = Decreased**

Physical Exam	N	A	I	D	Location/Specifics	Comments
Tone						
DTR's (specify degree)						
Fine Motor						
Strength						
Gross Motor						
Feeding						
Range of Motion						

Recent Tests	Results
CT Scans / MRI's	

DME	Type	Comments
Existing Equipment		
Existing Bracing		

Relevant Medical History and Referrals: ____

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____

Physician's Signature:________________________Lic#__________________ Physician's NPI#: _________________

Physician's Name (printed): ________________________Telephone:______________ Date: ___________Time:_______

PLEASE ATTACH CURRENT RECORDS AND / OR REPORTS

Please mail, fax or email to:

Ventura County Public Health
Children's Medical Services/CCS
2240 E. Gonzales Road Suite 260
Oxnard, CA 93036

FAX: (805) 658-4580

E-MAIL: PHCCS@ventura.org

MTP PHYSICIAN'S REFERRAL

VENTURA COUNTY HEALTH CARE AGENCY

Patient Label
or
Two Patient Identifiers