Family Foundations Therapy

Empowering Families by Building Foundations

REFERRAL FORM

Forms can be faxed to 1-639-739-1773
OR emailed to support@familyfoundationstherapy.com
You will receive a confirmation phone call/email within 1 week of sending referral

REFERRAL FOR: **Occupational Therapy** ☐ **Orofacial Myofunctional Therapy** ☐ **Referral Date:** M/D/Y _____

Client's Name: _____ D.O.B. (M/D/Y) _____ Gender: _____
Allergies/Medications: _____

FAMILY INFORMATION

Parent/Caregiver(s): _____ _____

Preferred contact method: Phone ☐ Text ☐ Email ☐
Phone(s): _____ _____
Email(s): *_____ _____

☐ ***I understand and accept the risks of sending confidential information (such as reports) by e-mail***

Client/Family's Main Concerns: _____

_____

_____

Breastfeeding & Oral Motor Assessment
(by Certified Breastfeeding Specialist & OTR) ☐

Myofunctional Therapy 4 years to Adult
(TMD, sleep, noxious habits, lingual frenum, tongue position) *See OMT referral document* ☐

Tethered Oral Tissue (Lingual/Labial Frenum) Assessment ☐
(by TOTS Training® Specialist)
- **Pre Release therapy** ☐
- **Wound Care** ☐
- **Post Release Therapy** ☐
- **Body Work** ☐

Infant/Pediatric Occupational Therapy Services ☐

Infant & Maternal Mental Wellness ☐

Pregnancy & Postpartum Corrective Exercise ☐

Body Work (CST, OMT, Infant Specialized Tummy Time) ☐

REFERRAL INFORMATION

Referral Source: _____Phone/Fax: _____Email:_____
How did you hear about us? _____

OTHERS INVOLVED

Services*: (e.g. PT, SLP):*_____ _____
Physician name/address: _____

I have read the information above, it is correct and I agree to this referral.

Parent signature: _____ **Date** (M/D/Y) _____

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E. support@familyfoundationstherapy.com
www.familyfoundationstherapy.com

OFFICE USE ONLY:

○ Contacted referral source	○ Entered into FFT	○ Informed of estimated Wait
○ Received _____	○ Date onto Caseload _____	○ Wait time _____
○ Contacted #1 _____	○ #2 _____	○ #3 _____
○ Referred out _____	○ Ineligible _____	○ D/C date _____