Gig Harbor Pediatric Occupational Therapy Referral Form

Occupational Therapist name: Megan Lesh OTR/L
Practice address: 806 24th Ave NW Gig Harbor WA 98335
Phone: 714-917-5694

Patient and Caregiver Information

Patient full name: _____

Date of birth: _____

Gender: _____ Pronouns_____

Parent/Guardian name(s): _____

Relationship: _____

Parent/Guardian occupation:_____

Home street address: _____

City: _____State: _____Zip: _____

Phone #: _____

Email: _____

Insurance Information *(fill in or scan card)*

Subscriber name: _____

Primary subscriber date of birth: _____

Health Plan: _____

Group # _____

Member ID (with prefix and suffix):

_____

Secondary Insurance (if any):_____

Health Care Provider information

Referring provider name: _____

Office name: _____

Office phone #: _____

Office fax #: _____

Office street address: _____

City: _____ State:_____ Zip: _____

To be completed by referring provider

Diagnosis

Diagnosis ICD-10 code: _____

Precautions: _____

Referral for: (check)

☐ OT Evaluation and Treatment

☐ Other:_____

Specific related concerns by caregiver/patient/provider:

_____

_____

_____

Referring Provider signature:

_____

Provider name printed:

_____

Date: _____

- When completed, the medical office or the caregiver can either mail referral to above address or scan/email to meganlesh@gigharborpediatricot.com
- Or bring the signed referral to your first session if I will be seeing you very soon 😊