Referral Request

MOSAIC Rehabilitation
Bettering the lives of those we serve

Bellevue Location
13010 N.E. 20th St, Suite 300
Bellevue, Washington 98005
Phone: (425) 644-6328
Fax: (425) 644-6295

Issaquah Location
1495 NW Gilman Blvd, Suite 4
Issaquah, Washington 98027
Phone: (425) 392-2346
Fax: (425) 392-0185

Seattle Location
2111 N Northgate Way, Suite 101
Seattle, Washington 98133
Phone: (206) 388-3751
Fax: (206) 556-4515

Date: _____
From: _____
_____
Phone Number: _____
# of Pages: _____ (including cover)

We are referring the following patient to MOSAIC Children's Therapy Clinic for the selected therapy services. We understand that it is the patient's responsibility to contact MOSAIC to schedule an appointment.

Child's Name: _____ Date of Birth: _____

Referring Diagnosis: _____ **ICD-10 Code:** _____
_____ _____

Patient Insurance: _____
(Please provide the name of the patient's insurance company)

Requested service(s) to be provided:

- ☐ **ABA** - for _____ x/week for _____ # of weeks
- ☐ **Occupational Therapy** – for _____ x/week for _____ # of weeks
- ☐ **Physical Therapy** - for _____ x/week for _____ # of weeks
  - ☐ Ankle-Foot Orthotics
- ☐ **Speech/Social Skills** - for _____ x/week for _____ # of weeks
- ☐ **Psychological Services –** for _____ x/week for _____ # of weeks
- ☐ **Other:** _____

Additional Comments: _____
_____
_____
_____
_____
_____

I deem that the above professional rehabilitative treatments are indicated and medically necessary for this patient's therapeutic program.

Physician Signature: _____ Date: _____