PATIENT REFERRAL FORM

FAX COMPLETED FORM TO: (317) 818-1756

Seattle Sensory Learning is part of SENSORY LEARNING CENTER

INTRODUCING: _____ DOB: _____ DATE: _____

PARENT/S OR GUARDIAN/S: _____

RECOMMENDATION: Sensory Integration Evaluation for the following concerns (check all that apply)

- ❑ Inattention
- ❑ Sensory Integration Delays
- ❑ Autistic Spectrum Disorder
- ❑ Traumatic Brain Injury
- ❑ Learning Challenges
- ❑ Stroke
- ❑ Eye Teaming Delays
- ❑ Concussion
- ❑ Body posture, orientation and stability to vision tasks - includes dizziness, motion sickness, and attention deficits
- ❑ OTHER CONCERNS / SYMPTOMS / CONDITION: _____

REFERRING PROFESSIONAL: _____

PHONE: _____ FAX: _____

Or place stamp or attach business card here:

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Check if needed:

- ❑ Please send additional referral forms
- ❑ Please send handouts/ brochures / cards

I acknowledge being informed that **my health care practitioner/educator** has recommended I be seen for a consultation regarding the Sensory Learning Program as a viable potential treatment to address my current health/educational concerns. I give permission to give **Mary Wong VanHoy, or her staff**, permission to contact me regarding scheduling a consultation by telephone or in her clinic to discuss the Sensory Learning Program, its features and benefits as it pertains to my condition

BEST PHONE NUMBER TO CALL: _____ BEST TIME OF DAY TO CALL: _____

- ❑ Please call this family to set up an appointment
- ❑ The family would like to call themselves to set up an appointment

_____ Client/ Parent/ Guardian

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