



Rehabilitation Services

Motivating Mealtimes Physician Referral

Child's name: _____ DOB: _____ Gender: _____

Child's SSN#: _____ Interpreter: _____ Language: _____

Parent/guardian: _____ Phone: () _____

DCS caseworker: _____ County: _____ Phone: () _____

Address: _____
Street City State ZIP

Insurance: _____ Authorization: _____

MEDICALLY RELATED DIAGNOSIS: _____ ICD-10: _____

Services Requested

Motivating Mealtimes Evaluation, Comment(s): _____

which will include: _____

- Oral Motor/Feeding Therapy Evaluation and Treatment
- Occupational Therapy Evaluation and Treatment
- Medical Nutrition Therapy Evaluation and Treatment
- Behavioral Health Evaluation and Treatment

Physician signature: _____ Date: _____

Print physician name: _____

Office contact phone number: _____

Return by fax to: (865) 246-7562

Return by email to: motivatingmealtimes@etch.com

**East Tennessee Children's Hospital
Downtown Rehabilitation Services
Medical Office Building, Suite 130
2100 W Clinch Avenue
Knoxville, TN 37916
Phone: (865)541-8912**