



**Carolina
Therapeutics**

LACTATION CONSULTING REFERRAL

Infant Name: _____ DOB: _____

Mother Name: _____ Phone No: _____

Current Infant Measurements

Measurements	Date Taken	Data
<i>Weight</i>		Lbs. Oz. %
<i>Height</i>		Lbs. Oz. %
<i>BMI</i>		%

Measurements At Birth

Measurements	Data
<i>Gestational Age</i>	weeks days
<i>APGAR Scores</i>	
<i>Weight</i>	Lbs. Oz. %
<i>Height</i>	Lbs. Oz. %
<i>BMI</i>	%

Professional Therapy Services When & Where You Need Us!
www.carolinatherapeutics.com · info@carolinatherapeutics.com
Tel 704.654.8599 · Fax 980.938.6088



Carolina Therapeutics

NICU /Birth History

Referral Type	Date of Referral	Name of Specialist/Practice
<i>Most Recent Swallow Study</i>		
<i>Concerns First Reported</i>		
<i>Gastroenterology</i>		

Past/Existing Patient Referrals and Specialists

Referral Type	Date of Referral	Name of Specialist/Practice
<i>Most Recent Swallow Study</i>		
<i>Gastroenterology</i>		
<i>Dietician</i>		
<i>Otolaryngologist</i>		
<i>Pulmonologist</i>		
<i>Cardiologist</i>		
<i>Additional Therapies</i>		



**Carolina
Therapeutics**

Diagnoses Regarding the Infant

Commonly Used ICD-10 Codes for Feeding and Swallowing Disorders (Check all that apply)

<input type="checkbox"/>	E46 Applicable to malnutrition, not otherwise specified (NOS) Protein-calorie imbalance NOS	<input type="checkbox"/>	R13.10 Dysphagia, unspecified
<input type="checkbox"/>	F50.82 Avoidant restrictive food intake disorder	<input type="checkbox"/>	R13.11 Oral phase dysphagia
<input type="checkbox"/>	G80.9 Cerebral Palsy, unspecified	<input type="checkbox"/>	R13.12 Oropharyngeal phase dysphagia
<input type="checkbox"/>	K21.9 Gastro-esophageal reflux	<input type="checkbox"/>	R13.13 Pharyngeal phase dysphagia
<input type="checkbox"/>	P07.0 Extremely low birth weight newborn	<input type="checkbox"/>	R13.14 Pharyngoesophageal dysphagia
<input type="checkbox"/>	P07.1 Other low birth weight newborn	<input type="checkbox"/>	R19.4 Change in bowel habit
<input type="checkbox"/>	P07.2 Extreme immaturity of newborn	<input type="checkbox"/>	R19.5 5 Other fecal abnormalities
<input type="checkbox"/>	Q31.5 Congenital laryngomalacia	<input type="checkbox"/>	R19.7 Diarrhea, unspecified
<input type="checkbox"/>	Q31.8 Congenital malformations of the larynx	<input type="checkbox"/>	R19.8 Other specified symptoms and signs involving the digestive system and abdomen
<input type="checkbox"/>	Q35.9 Cleft palate, unspecified	<input type="checkbox"/>	R62.0 Delayed milestone in childhood
<input type="checkbox"/>	Q38.1 Ankyloglossia	<input type="checkbox"/>	R62.5 Other and unspecified lack of normal physiological development in childhood
<input type="checkbox"/>	Q38.5 Congenital malformation of the palate (high arched palate)	<input type="checkbox"/>	R62.51 Failure to thrive in child over 28 days old
<input type="checkbox"/>	Q39.1 Atresia of the esophagus without fistula	<input type="checkbox"/>	R63.31 Feeding difficulties, acute
<input type="checkbox"/>	Q75 Micrognathia	<input type="checkbox"/>	R63.32 Feeding difficulties, chronic
<input type="checkbox"/>	Q90.9 Down Syndrome, unspecified	<input type="checkbox"/>	R63.4 Abnormal weight loss
<input type="checkbox"/>	Q99.9 Chromosomal abnormality, unspecified	<input type="checkbox"/>	R63.5 Abnormal weight gain
<input type="checkbox"/>	Z93.1 Gastrostomy status	<input type="checkbox"/>	R63.6 Underweight
<input type="checkbox"/>	Other:		

Physician's
Signature:

Date:

Physician's
Printed Name:

NPI#:

***When signed by a physician, this form acts as a prescription for Feeding / Lactation Consulting services.
Please fax this form along with any additional relevant medical information to 980-938-6088.***

Professional Therapy Services When & Where You Need Us!
www.carolinatherapeutics.com · info@carolinatherapeutics.com
Tel 704.654.8599 · Fax 980.938.6088



Diagnoses Regarding the Mother

Commonly Used ICD-10 Codes for Feeding and Swallowing Disorders (Check all that apply)

<input type="checkbox"/> B37.89 Candidiasis, breast or nipple	<input type="checkbox"/> O92.3 Agalactia
<input type="checkbox"/> L01.00 Impetigo, unspecified	<input type="checkbox"/> O92.4 Hypogalactia
<input type="checkbox"/> O91.02 Infection of nipple associated with the puerperium	<input type="checkbox"/> O92.5 Suppressed lactation
<input type="checkbox"/> O91.03 Infection of nipple associated with lactation	<input type="checkbox"/> O92.6 Galactorrhea
<input type="checkbox"/> O91.13 Abscess of breast associated with lactation/Mastitis purulen	<input type="checkbox"/> O92.70 Unspecified disorders of lactation
<input type="checkbox"/> O91.23 Nonpurulent mastitis associated with lactation	<input type="checkbox"/> O92.79 Galactocele (Other disorders of lactation)
<input type="checkbox"/> O92.03 Retracted nipple associated with lactation	<input type="checkbox"/> Z39.1 Encounter for care and examination of lactating mother <i>(Excludes encounter for conditions related to O92.-)</i>
<input type="checkbox"/> O92.13 Cracked nipple associated with lactation	
<input type="checkbox"/> Q83.8 Other congenital malformations of breast (ectopic or axillary breast tissue)	<input type="checkbox"/> Z09 Encounter for follow-up examination after completed treatment <i>(When the original reason for visit has resolved)</i>
<input type="checkbox"/> R20.3 Hyperesthesia (burning)	
<input type="checkbox"/> R53.83 Fatigue	
<input type="checkbox"/> Other:	

Physician Signature & Referral

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ NPI#: _____

When signed by a physician, this form acts as a prescription for Lactation Consulting services. Please fax this form along with any additional relevant medical information to 980-938-6088.