YOUR LOGO
(optional)

CLINIC / PRACTITIONER NAME

Form OT-APPT-01

Address · phone · license #

Occupational Therapy Appointment Request

Client details, referral information, and scheduling preferences for booking OT appointments.

CLIENT INFORMATION

Client name

Date of birth

Phone

Email

Address

CAREGIVER / RESPONSIBLE PARTY

Name

Relationship to client

Phone

Email

APPOINTMENT REQUEST

Service requested

Preferred provider

Preferred days

Preferred times

Location / clinic

In person or telehealth

REFERRAL & INSURANCE

Referring provider

NPI

Diagnosis / ICD-10

Referral date

Insurance plan

Member ID

Group #

Authorization # / units

DATE	TIME	SERVICE	PROVIDER	LOCATION

ACKNOWLEDGEMENTS

- ☐ I have read and accept the cancellation / no-show policy
- ☐ I consent to appointment reminders by email
- ☐ I consent to appointment reminders by text message
- ☐ I confirm the insurance details above are accurate

ADDITIONAL NOTES

Continuation, observations, or notes

SIGNATURES

I request the appointment(s) above and confirm the information provided is accurate to the best of my knowledge.

Client / guardian signature

Date

Staff signature

Date