Speech Therapy Prescription

Patient Name: ______________________________D.O.B: _______________Date:__________

Parent's Name: ______________________________Phone Number: _____________________

Referring Physician: ________________________ Office Number: ______________________

- ☐ Speech Therapy Evaluate and Treat as Necessary

Medical Diagnoses (if applicable): ____

<u>Speech Modalities:</u>

- ☐ Feeding/Oral Motor
- ☐ Cognition
- ☐ Language
- ☐ Articulation
- ☐ Augmentative Communication
- ☐ Fluency
- ☐ Voice
- ☐ Auditory Verbal
- ☐ Literacy
- ☐ Auditory Processing
- ☐ Comprehensive Speech and Language

Speech Therapy Diagnostic Code: ____

- ☐ Special Instructions/Other: ____

Physician Signature: ________________________________Date:__________ Time: _________

NPI# ____

FAX ALL THERAPY PRESCRIPTIONS TO: 844-559-5504