



120 N Perkins Road Suite F Stillwater, OK 74075 ❖ 405.564.2701 ❖ www.ats-stillwater.com

FEES Order Form

Refer for Speech-Language Pathology services for evaluation and treatment of dysphagia.

- Clinical Swallow Evaluation
- Fiberoptic Endoscopic Evaluation of Swallowing (FEES)
- Dysphagia Treatment

FEES Authorization

- SLP may perform and repeat FEES as clinically indicated, including use during treatment for assessment, biofeedback, and plan of care modification
- SLP may develop and modify the plan of care, provide treatment, diet recommendations, and caregiver education

Referring Provider: _____

Referring Provider Fax #: (_____) _____ - _____

Referring Provider Phone #: (_____) _____ - _____

Patient Name: _____

Patient DOB: ____ / ____ / ____

Patient Phone Number: (_____) _____ - _____

Primary Insurance: _____ Policy#: _____

Secondary Insurance: _____ Policy #: _____

Primary diagnosis (ICD-10): _____

All pertinent medical diagnoses (ICD-10): _____

Please include copies of insurance card, patient face-sheet, last office visit note, and any other pertinent records or test results.

Comments/Reason for Referral:

I certify these services are medically necessary and approve the plan of care, including FEES as part of evaluation and treatment as needed.

Provider (printed): _____

Provider (signature): _____ Date: _____

**Please submit this form and related information via fax to 888-581-6850
or via email to therapy@ats-stillwater.com**