

Pediatric and Adult Therapy Services
3737 Government Blvd, Suite 306
Mobile, AL 36693
Phone: (251) 379-0580 | Fax: (844) 971-1940
Email: kimikopears@pats-llc.com

Speech Language Therapy Referral Form

Patient Information

Patient Name: _____

Date of Birth: _____

Parent / Guardian, if applicable: _____

Preferred Phone: _____ Okay to leave voicemail? ☐ Yes ☐ No

Secondary Phone (optional): _____ Okay to leave voicemail? ☐ Yes ☐ No

Referring Physician / Provider Information

Provider Name / Credentials: _____

Practice / Office Name: _____

National Provider Identifier (NPI): _____

Phone: _____ Fax: _____

Referral Order

Diagnosis / ICD-10 Code, if known: _____

Reason for Referral: _____

_____

☐ Speech-language evaluation

☐ Speech-language evaluation and treatment as indicated

Referring Provider Signature: _____ Date: _____

This form is not required if your office submits a signed and dated referral with all required patient, referring provider, and clinical information.

Fax referrals to (844) 971-1940. Include a demographic sheet and relevant clinical notes, if available.

Revised November 2026