NATURALLY SPEAKING
SPEECH & LANGUAGE THERAPY SERVICES

SPEECH THERAPY REFERRAL & INTAKE FORM
(FAX OR EMAIL) FAX: 704-935-5305
EMAIL: MEKA@NATURALLYSPEAKINGINC.ORG

TODAY'S DATE:____________________ PERSON MAKING REFERRAL:_______________________

PRIMARY CONCERN: ____

PATIENT'S FULL NAME: ____

PATIENT'S DOB: ________________ GENDER:_________

PRIMARY LANG: _________________

ADDRESS: ____________________________________ CITY: _______________STATE: _______

SCHOOL/DAYCARE NAME: _____________________________________ CITY: ______________

CURRENT IEP/IFSP: _____YES _____NO PATIENT'S CURRENT GRADE:___________________

PREVIOUS/CURRENT THERAPY:
____

OTHER SERVICES: ____

PARENT'S/GUARDIAN NAME: ____

TELEPHONE#:________________________ EMAIL: ____________________________________

PRIMARY INSURANCE:____________________________ POLICY#: _______________________

GROUP#: _____________________________ INSURANCE PHONE#: _____________________

SUBSCRIBER'S NAME:______________________________ DOB: _________________________

RELATIONSHIP TO PATIENT: ____

PATIENT'S PHYSICIAN'S NAME:____

PHYSICIAN'S OFFICE: ____

SERVICE DELIVERY: _________HOME ______ DAYCARE/SCHOOL ______VIRTUAL/ONLINE

****SELF PAY CLIENT'S MUST COMPLETE A CREDIT CARD AUTHORIZATION FORM****