SPEECH THERAPY ASSOCIATES

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REFERRAL FOR SPEECH THERAPY **TODAYS DATE: ______________**

Patient Name:	DOB:
Patient Home Phone:	Cell Phone:
Diagnosis:	ICD-10 Code(s):
Referring Physician: NPI:	Phone: Fax:

EVALUATION AND TREATMENT NEEDED:

☐ - Speech/Language Evaluation
☐ - Voice Evaluation
☐ - Cognitive/Memory Eval
☐ - MODIFIED Barium Swallow (MBS)
☐ - VPC (Velo-pharyngeal competency)

☐ - Speech Therapy
☐ - Voice Therapy
☐ - Swallowing Therapy
☐ - NMES Therapy
☐ - Cognitive Therapy

****Please attach insurance card(s), patient demographics and current clinical notes, test results, etc.**

I certify that these services are medically necessary for this patient.

Physician Signature:

____ Date: _________________