



20055 SW Pacific Hwy. Suite 106 Sherwood, OR 97140

Ph. (503) 610-6145 | Fax (971) 979-1097

[www.TheABClinic.com](http://www.TheABClinic.com)

## Speech Therapy Physician/Provider Referral Form

Patient's Full Name:

Parent or Guardian's Full Name:

Patient's DOB:

Patient's address:

Patient's Phone:

Insurance Carrier:

Member ID:

Group Number:

Physician/Referring Provider's Full Name:

Physician/Referring Provider's phone:

Physician/Referring Provider's Email:

Practice Name:

Practice address:

Practice Fax #:

### **Reason for Referral:**

Commonly used ICD-10 Codes (check all that apply)

F80.0 -- Phonological Disorder/Articulation Disorder/Speech-Sound Disorder

F80.1—Expressive Language Disorder

F80.2—Mixed Receptive-Expressive Language Disorder

F80.81—Childhood Onset Fluency Disorder



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F80.82—Social Pragmatic Communication Disorder

R13.10—Dysphagia, unspecified

R13.11-- Dysphagia, oral phase

R63.3—Feeding difficulties

R41.841—Cognitive Communication Deficit

R41.844—Frontal Lobe and Executive Function Deficit

R47.49—Other Speech Disturbance

Other: (please list any specific ICD-10 Code and description)

**Speech-Language Pathology Service(s):**

Evaluation only

Evaluation and Treatment

\_\_\_\_\_  
Physician/Referring Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician/Referring Provider's NPI #

**Please Fax To: (971) 979-1097**

OR upload to patient portal on [www.TheABClinic.com/Patient-Portal](http://www.TheABClinic.com/Patient-Portal)