SOUTH BAY
Speech Therapy Clinic, PC

21151 S. Western Ave, Suite 119 Torrance, CA 90501
Please call: 310-373-7599
email: contact@southbayspeechclinic.com | fax: 310-347-4132

SWALLOW/ SPEECH/ LANGUAGE/ VOICE/ COGNITION

Client: _____ Physician: _____

Date of Birth: _____ Date of Referral: _____

Insurance: _____

Diagnosis: _____ Precautions: _____

_____ _____

_____ _____

Reason for referral:

- ☐ Chronic cough
- ☐ Paradoxical vocal fold movement/VCD
- ☐ Muscle Tension Dysphonia
- ☐ Vocal fold nodules/Vocal fold polyps
- ☐ Pre and post vocal fold surgery care
- ☐ Presbyphonia
- ☐ Parkinson's related speech and swallowing issues
- ☐ Swallowing disorders
- ☐ Others, please specify _____

Frequency/ Duration:

MD Signature: _____ Date: _____

Please fax referrals to 310-347-4132 with the following:

- ALL physician's notes
- Facesheet with demographics and insurance information