PHYSICIAN’S REFERRAL FORM

PHYSICIAN’S SIGNATURE: _______________________________________    DATE: _______________

TREATMENT INFORMATION

☐ Speech Evaluation (Procedure Code: 92523)    ☐ Speech Therapy (Procedure Code: 92507)

☐ F80.0 Speech Articulation Developmental Disorder
☐ F80.1 Expressive language Disorder
☐ F80.2 Mixed Receptive-Expressive Language Disorder
☐ F80.4 Speech and Language Developmental Delay Due To Hearing Loss
☐ F84.0 Autistic Disorder

☐ F80.81 Childhood Onset Fluency Disorder
☐ F80.89 Other Developmental Disorders of Speech and Language
☐ F78 Other Intellectual disabilities
☐ F71 Moderate Intellectual Disabilities
☐ F73 Profound Intellectual Disabilities

☐ F90.9 ADHD
☐ R48.2 Apraxia of Speech
☐ Q90.0 Down Syndrome
☐ R13.10 Dysphagia
☐ R49.9 Voice Disturbance
☐ Q35.9 Cleft Palate, unspecified

☐ Other: ________________

☐ PARENT CONCERNS: ________________________________
______________________________