SPEECH THERAPY PRESCRIPTION & REFERRAL FORM

Client Name: ______________________________ Date of Birth: ________________

Client Address: ____

Contact Name: ____________________________ Relationship to Client: ___________

Preferred Contact Phone Number: ____

Speech Therapy Evaluation and Treatment for (select all that apply):

- ☐ Speech
- ☐ Language
- ☐ Swallowing
- ☐ Feeding Difficulties
- ☐ Cognition
- ☐ Apraxia
- ☐ Voice

Comments: ____

Specialty Program Request:

Neuromuscular Electrical Stimulation for dysphagia (VitalStim)
PROMPT (PROMPTs for Restructuring Oral Muscular Phonetic Targets)

Medical Diagnosis and ICD-10 Codes (List all that relate to current deficits/concerns):

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____

Treatment Diagnosis and ICD-10 Codes (e.g., dysphagia, aphasia, dysarthria, etc.):

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Physician's Signature: ______________________________ Date: ________________

Physician's Printed Name: ____

NPI#: __________________________ Phone Number: _______________________

When signed by a physician, this form acts as a prescription for therapy services. Please fax this form along with any additional relevant medical information to 972-544-6390.