SPEECH LANGUAGE AND BEYOND, LLC

"Taking speech and language skills over and beyond"

REQUEST FOR PRESCRIPTION FOR SPEECH THERAPY SERVICES (APPROPRIATE FOR ALL AGES)

Referred by: ____

Office Phone: __________________ Office Fax: _______________________

Patient Information Required

Patient Name: ___________________________ DOB: ________________

Parent's Name (if patient is a minor) _______________________________________

Patient Home Address: ____

Parents' Contact Information: (hm) _________________ (cell) ________________

Insurance Information: Primary _____________________________________

Secondary_____________________________________

Patient Hx Information Relevant to Referral:

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Reason for Referral/Diagnoses

__Articulation problems (saying sounds incorrectly) __Auditory processing __Receptive language problems (difficulty comprehending and following directions

__Expressive language (using words, sentence, written expression to communicate) __Fluency (stuttering)

__Voice (hoarse/strained vocal tone, too low/too high pitch) __Oral Motor (trouble with tongue/lip muscles)

Physician Signature: ________________________________ Date: _______________________________

You may forward the completed form via our secured fax line (229) 496-5277. Thank you for this referral.

A complete diagnostic report will be forwarded to your office for review and signature (if needed) when the assessment is completed .

Speech Language and Beyond, LLC
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