



**CENTRAL TEXAS  
SPEECH PATHOLOGY SERVICES, INC.**

**REFERRAL INTAKE FORM**

Please fax form to 512.327.1545 or call the office at 327.6179. More information can be found at [www.CentralTexasSpeech.com](http://www.CentralTexasSpeech.com)

Today's Date:

**PATIENT INFORMATION:**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_

Guardian Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Primary Language:  English  Spanish  Other:

Patient Availability:  Any  Mornings  Afternoons  Afterschool  Other:

Place of Service:  Clinic  Home  Other:

**INSURANCE INFORMATION (PLEASE PROVIDE COPY OF CARD):**

Primary Insurance: \_\_\_\_\_ Patient ID: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Patient ID: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_ Insurance Address: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Group No.: \_\_\_\_\_ Policy No.: \_\_\_\_\_ Co-Payment: \$ \_\_\_\_\_

**Referral/Physician Information:**

Referring Physician's Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

**Treatment Information:**

**Referring Diagnosis:**

- |   |   |
|---|---|
| <input type="checkbox"/> 299.00 Autistic Disorder                         | <input type="checkbox"/> 478.5 Other Diseases of Vocal Cords        |
| <input type="checkbox"/> 307.0 Adult Onset Fluency Disorder               | <input type="checkbox"/> 749 Cleft Palate and Cleft Lip             |
| <input type="checkbox"/> 315.31 Expressive Language Disorder              | <input type="checkbox"/> 758.00 Down Syndrome                       |
| <input type="checkbox"/> 315.32 Mixed Expr./Recep. Lang. Disorder         | <input type="checkbox"/> 784.4 Voice and Resonance Disorders        |
| <input type="checkbox"/> 315.35 Childhood Onset Fluency Disorder          | <input type="checkbox"/> 784.59 Other Speech Disturbances, NOS      |
| <input type="checkbox"/> 315.39 Other Developmental Articulation Disorder | <input type="checkbox"/> 787.21 Dysphagia, Oral Phase/Tongue Thrust |
| <input type="checkbox"/> 389 Hearing                                      | <input type="checkbox"/> Other: _____                               |

**MEDICATIONS:**

I certify that this patient is under my care. The therapeutic services prescribed by me are medically necessary and in accordance with a plan established and periodically reviewed by me:

**Physician's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_