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

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 (ICD-9/ICD-10)

- □ 299.00/F84.9 Autistic Disorder
- □ 307.0/F98.5 Adult Onset Fluency Disorder
- □ 315.31/F80.01 Expressive Language Disorder
- □ 315.32/F80.2 Mixed Expr./Recep. Lang. Disorder
- □ 315.35/F80.81 Childhood Onset Fluency Disorder
- □ 315.39/F80.0 Other Developmental Articulation Disorde
- □ 389.00/H90.2 Hearing
- □ 434.91/I63.50 CVA
- □ 161.0-209.36/C32.9-C4A.9 Cancers of head and neck
- □ 478.5/J38.2 Other Diseases of Vocal Cords (VCD); nodules
- □ 749.00/Q35.9 Cleft Palate and Cleft Lip
- □ 786.2/R05 Cough
- □ 784.4/R49.9 Voice and Resonance Disorders
- □ 784.59 Other Speech Disturbances, NOS
- □ 787.21/R13.11 Dysphagia, Oral Phase/Tongue Thrust
- □ 787.29/R13.19 Other Dysphagia
- □ 799.52/R41.841 Cognitive communication deficit
- □ 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:**