BILINGUISTICS

SPEECH AND LANGUAGE SERVICES
1505 W. Koenig Ln
Austin, TX 78756
512-480-9573

PHYSICIAN'S REFERRAL FORM

FAX COMPLETED FORM TO 512-458-9573

EXPERTS IN TREATING PATIENTS THAT SPEAK ALL LANGUAGES.

Today's Date:

PATIENT INFORMATION

Patient's Name:	Date of Birth:	Gender: _____
Address:		
Guardian Name:	Relationship to Patient:	
Home Phone:	Alternate Phone:	Email:

Primary Language Spoken In Home: ☐ English ☐ Spanish ☐ Other:

Service Delivery: ☐ Clinic ☐ Teletherapy

INSURANCE INFORMATION (PLEASE PROVIDE COPY OF CARD.)

Primary Insurance:	Medicaid/Patient ID:		
Secondary Insurance:	Medicaid/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:

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

PHYSICIAN'S SIGNATURE: _____ DATE: _____

TREATMENT INFORMATION

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

Referring Diagnosis

- ☐ 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
- ☐ F70 Mild 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**: _____

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