ALIGN
SPEECH THERAPY AND CONSULTING

Physician Referral Form

Patient's Name: _____ Date of Birth:_____

ICD.10 Diagnosis:_____

Contact Name: _____ Contact Number: _____

Please indicate which services you would like Align Speech Therapy and Consulting LLC to perform from the list below. **(PLEASE INITIAL NEXT TO YOUR REQUESTED SERVICE or SERVICES)**

_____ Evaluation of Speech Sound Production with Evaluation of Language (92523)
_____ Evaluation of Speech Sound Production (92522)
_____ Clinical Evaluation of Swallowing / Evaluation of Swallowing Function (92610)
_____ Behavioral and Qualitative Analysis of Voice and Resonance (92524)
_____ Treatment of Speech, Language, Voice Communication and/or Auditory Processing (92507)
_____ Treatment of Swallowing Dysfunction / Oral Function Therapy for Feeding (92526)
_____ Cognitive Function Intervention/Treatment (97127)
_____ Evaluate and treat as indicated

NOTES:_____

Physician Name: _____
Practice Location: _____ Phone Number:_____
Physician SIGNATURE (mandatory):_____**Date:**_____

If you have any questions, please feel free to **contact us at (843) 936-0020**

Please fax (1) Referral (2) History and Physical (3) Most Recent Physician Note and (4) Related testing results, i.e. Laryngoscopy, MRI, etc. to (855) 718-2654