



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

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