**Speech-Language Pathology Evaluation/Treatment Referral Form**

**Patient First Name:** 

**Patient’s Last Name:** 

**Patient’s Date of Birth:** Click or tap to enter a date.

**Patient’s Phone Number:** 

**Primary Diagnosis & ICD-10 Code:** 

**Secondary Diagnosis & ICD-10 Code:** 

**Date of Onset/Injury:** Click or tap to enter a date.

**Physician Findings:** Click or tap here to enter text.

**CPT Evaluation & Treatment Code**

Behavioral and Qualitative Analysis of Voice and Resonance (92524)

Speech Therapy (92507)

Clinical Swallow Evaluation (92610)

Swallowing Therapy (92526)

Evaluation of speech sound production (i.e., articulation, dysarthria) (92522)

Evaluation of speech sound production w/ evaluation of language comprehension and expression (e.g. dysarthria, expressive and receptive language) (92523)

Standard Cognitive Performance Testing (96125)

Development of cognitive skills, each 15 minutes (97129 and 97130)

**Physician Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Name: **

**Physician Phone: **

**Physician Fax: **

**Referral Date:** Click or tap to enter a date.