**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.