Feed Talk Grow Pediatric Therapy
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PHYSICIAN FAX REFERRAL FORM
PEDIATRIC SPEECH LANGUAGE PATHOLOGY

Patient's name: _____ DOB: _____

Parent/Guardian: _____ Phone: _____

Reason for referral: ☐ Speech therapy eval & treat ☐ Feeding therapy eval & treat

Medical diagnosis: _____

ICD-10 Code:

- ☐ R48.2 Apraxia
- ☐ F84.0 Autism
- ☐ F80.0 Articulation or phonological disorder
- ☐ F80.81 Childhood onset fluency disorder
- ☐ R47.1 Dysarthria
- ☐ R13.11 Dysphagia, oral phase
- ☐ F80.1 Expressive language disorder
- ☐ R63.30 Feeding difficulties, unspecified
- ☐ F80.2 Mixed receptive-expressive language disorder
- ☐ R63.39 Other feeding difficulties
- ☐ R63.31 Pediatric feeding disorder, acute
- ☐ R63.32 Pediatric feeding disorder, chronic
- ☐ F80.4 Speech and language development delay due to hearing loss
- ☐ Other: (please list code and description):

_____

PHYSICIAN SIGNATURE: _____ DATE OF REFERRAL: _____

PHYSICIAN NAME (PRINT): _____

PHYSICIAN PRACTICE NAME:_____

PHONE NUMBER: _____ FAX NUMBER: _____

Fax Referral to: 1 (866) 225-4790