VOCE
SPEECH
THERAPY

ADULT SPEECH THERAPY REFERRAL FORM

Patient Name: _____ Date of Birth: _____

Contact Name: _____ Phone:_____

Commonly Used ICD-10 Codes (Check all that apply)

☐	R13.10 Dysphagia, unspecified
☐	R13.11 Oral phase dysphagia
☐	R13.13 Pharyngeal phase dysphagia
☐	R47.01 Aphasia
☐	R47.1 Dysarthria
☐	R41.841 Cognitive communication deficit
☐	R48.2 Apraxia
☐	R49.0 Dysphonia
☐	R49.8 Unspecified voice and resonance disorder

Diagnoses Commonly Associated with Treatment (Check all that apply)

☐	F03 Unspecified Dementia
☐	F07.81 Postconcussional syndrome
☐	F64.0 Gender dysphoria
☐	F84.0 Autistic disorder
☐	F84.9 Developmental Disorder
☐	F90.0 Attention-deficit hyperactivity disorder
☐	G20 Parkinson's Disease
☐	G30.9 Alzheimer's disease, unspecified
☐	G31.01 Primary Progressive Aphasia
☐	G31.84 Mild cognitive impairment
☐	I63.9 Cerebral infarction, unspecified

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ NPI#: _____

Please fax this form along with any additional medical information, clinic notes, and/or demographics to 615-634-4471 or 615-623-4273, or email to kristin@vocespeechtherapy.com if utilizing HIPAA compliant emailing.

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