West Tennessee Hearing & Speech Center

REFERRAL FORM

Return to **fax: (731) 668-7033**
Please attach patient demographic information, a copy of insurance information, and medication list.

Patient's Name: _____ **DOB:** _____

The person above has been recommended to receive the following service(s):

- ☐ **Speech therapy evaluation and treatment as indicated**
  - ☐ Articulation / Oral Motor
  - ☐ Language
  - ☐ Tethered Oral Tissue
  - ☐ Oral motor / Feeding
  - ☐ Stuttering / Fluency
  - ☐ AAC Device
  - ☐ Voice
  - ☐ Aphasia
  - ☐ Swallowing
  - ☐ Other: _____
- ☐ **Hearing evaluation and treatment as indicated**
  - ☐ Medically approved for hearing aids and/or hearing services

Primary Concern or Anticipated Diagnosis: _____

Medical / Physician's Diagnosis: ☐ Other: _____
Please send supporting documentation or additional reports.

- ☐ Autism Spectrum Disorder (F84.0)
- ☐ Cerebral Palsy (G80.9)
- ☐ Down Syndrome (Q90.9)
- ☐ Sensory Processing Disorder (G98.8)
- ☐ ADHD (F90.9)
- ☐ Dysphagia (R13.12
- ☐ Aphasia (R47.01)
- ☐ Sensorineural Hearing Loss (H90.3)
- ☐ Conductive Hearing Loss (H90.2)
- ☐ Unspecified Intellectual Disabilities (F79)

Special Orders or Precautions: _____

Primary Language Used: ☐ English ☐ Spanish ☐ Other: _____

_____ _____
Physician's Signature **Date**

Physician Name: _____ NPI#: _____

Practice Name, Address: _____

Phone #: _____ Fax #: _____