1801 E 51st, Ste. 365 #239
Austin, TX 78723
Tel: (512) 661-7971
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Cascada Resilient Therapy

Physician Referral Form for Adult Speech Therapy

Patient's Name: _____ Date of Referral: _____

Date of Birth: _____ Phone: _____

Diagnosis: _____

Reason for Referral: _____

_____

ICD-10 Code:

- ☐ R47.49—other speech disturbance
- ☐ R47.1—dysarthria and anarthria
- ☐ R47.81—slurred speech
- ☐ F80.81—childhood onset fluency (stuttering and/or cluttering) disorder
- ☐ R49.0—dysphonia/hoarseness
- ☐ R49.1—aphonia/loss of voice
- ☐ R49.2—hypernasality and hyponasality
- ☐ R49.8—other voice and resonance disorders
- ☐ F98.5—adult onset fluency disorder (stuttering and/or cluttering)
- ☐ F64.9—other gender identity disorder, unspecified
- ☐ Other: (please list # and description) _____

SERVICES:

(please circle) Speech-Language Pathology Feeding/Swallowing

(please circle) Evaluation / Treatment Evaluation Only

(please circle) Frequency: 1 2 3 4 5 days/week for 6 12 months

Physician's Signature: _____ Date: _____

Print name: _____ NPI #: _____

Clinic Name: _____ Phone number: _____

Additional Comments: _____

_____

Please fax this form to: (512) 379-0249