perennial
SLP | support · learn · play

Speech Therapy Referral Form

Patient Name: _____ DOB: _____

Parent/Guardian Name(s): _____

Phone: _____ Email: _____

SUSPECTED ICD-10 CODES (CHECK ALL THAT MAY APPLY):

- ☐ F80.0 Phonological / Articulation
- ☐ F80.1 Expressive Language
- ☐ F80.2 Receptive-Expressive Language
- ☐ F80.4 Speech Delay Due to Hearing Loss
- ☐ F80.81 Childhood Onset Stuttering
- ☐ F80.82 Social Communication Disorder
- ☐ F81.0 Dyslexia / Reading Disorder
- ☐ F94.0 Selective / Situational Mutism
- ☐ F98.5 Adult Onset Stuttering
- ☐ R41.841 Cognitive Communication
- ☐ R48.2 Apraxia of Speech
- ☐ R49.0 Dysphonia
- ☐ R49.1 Aphonia
- ☐ R49.2 Hypernasality or Hyponasality
- ☐ R63.3 Feeding Difficulties
- ☐ J38.5 Laryngeal Spasm / PVFM

Current diagnoses:

- ☐ F84.0 Autism
- ☐ Down Syndrome (ICD-10 _____)
- ☐ ADHD (ICD-10 _____)
- ☐ Hearing Loss (ICD-10 _____)
- ☐ R62.0 Delayed Milestone in Childhood
- ☐ F64.0 Gender Dysphoria
- ☐ F64.2 Gender Dysphoria in Childhood
- ☐ Intellectual Disability (ICD-10 _____)
- ☐ Hearing Loss (ICD-10 _____)
- ☐ Cleft Lip / Palate (ICD 10 _____)

Additional current diagnoses relevant to communication:

_____

_____

When signed by a physician, this form acts as a prescription for evaluation & therapy services.

Please fax this form, along with any additional relevant medical information to 773-598-8022.

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ NPI#: _____