THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER
Department of Audiology and Speech Pathology

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PATIENT REFERRAL FORM - *SPEECH-LANGUAGE*

Revised 9/2019

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Male/Female

Parent/Spouse/Guardian: _____

Address: _____City: _____State: ___Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PURPOSE OF REFERRAL [ ] Evaluation (including a hearing evaluation, if indicated)
[ ] Treatment

PLEASE NOTE: This referral is effective for *one year* for established patients from the date a properly completed and signed form is received. Our center will send requests to update referrals annually on established

AREAS OF CONCERN (check any that apply)

[ ] Speech [ ] Communication [ ] Traumatic Brain Injury [ ] Stuttering [ ] Apraxia [ ] Autism [ ] ALS
[ ] Language [ ] Voice [ ] Feeding/Swallowing [ ] Aphasia [ ] Cognition [ ] Parkinson's [ ] Reading

ADDITIONAL PROCEDURES [ ] Stroboscopy (Voice) [ ] Swallowing Evaluation: Fiberoptic Endoscopic Evaluation of Swallowing (FEES)

PERTINENT MEDICAL HISTORY with ASSOCIATED ICD-10 DIAGNOSIS CODE/S _____

_____

PROVIDER INFORMATION

Referring Physician: _____
Address: _____
Phone #: _____Fax #: _____
Provider's NPI:_____
Primary Care Provider: _____
Phone #: _____Fax #: _____
Provider's NPI: _____

- **Before we can schedule your patient and bill for insurance we must have the referring provider's NPI.**
- **Please also send *all* relevant medical notes or test results**

Is this patient currently receiving home healthcare services?

[ ] No [ ] Yes List Provider _____

INSURANCE INFORMATION

Primary Carrier:_____
Subscriber ID#: _____ Group #: _____
Secondary Carrier: _____
Subscriber ID#: _____ Group #: _____
Is a pre-cert or authorization number Required? Yes or No
Authorization/pre-cert #: _____# of visits: _____
Dates visits are valid: _____

AND

- **Send a copy of the patient's insurance card/s (front and back)**

Referring Provider's Signature (Required): _____ **Date:** _____