9995 Florida Blvd.
Walker, LA 70785
Tel: 225-283-5797
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Pediatric Speech Therapy Referral Form

Patient's Name: _____

Date of Referral: _____

Date of Birth: _____

Diagnosis: _____

Parent/Guardian: _____ Phone: _____

Insurance: _____

Reason for Referral: _____

ICD-10 Code:

- ☐ F84.0 Autistic disorder, Infantile autism
- ☐ F80.0 Articulation disorder, Phonological disorder
- ☐ F80.2 Mixed receptive-expressive language disorder
- ☐ F80.4 Speech and language development delay due to hearing loss
- ☐ F80.81 Childhood onset fluency disorder
- ☐ F80.82 Social pragmatic communication disorder (not Asperger's syndrome, not Autistic disorder)
- ☐ F81.0 Specific developmental disorders of scholastic skills (specific reading disorder)
- ☐ R63.3 Feeding difficulties, feeding problem NOS, picky eater
- ☐ P92.- Feeding problems of newborn (.1-Regurgitating & rumination / .2-Slow feeding / .3-Underfeeding / .8-Other feeding problems / .9-Feeding problem newborn, unspecified)
- ☐ F98.2 Other feeding disorders of infancy and childhood (not related to medical condition, not a newborn, not pica)
- ☐ R49.9 Unspecified voice and resonance disorder
- ☐ R47.8 Other speech disturbances
- ☐ R48.2 Childhood apraxia of speech
- ☐ R41.841 Cognitive communication deficit
- ☐ Other: (please list code & description) _____

Services For:

_____ Speech-Language Pathology _____ Feeding/Swallowing

Recommendation:

_____ Evaluation/Treatment _____ Evaluation Only

Frequency: 1 2 3 4 5 days/week for _____ weeks.

Physician's Signature: _____ Date: _____

Print Name: _____

Clinic Name: _____ Phone: _____

Please fax this form to: 225-425-3468