North Texas VOICE & SPEECH

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Speech Therapy Referral

Patient: _____ DOB: _____

Phone: _____ Date of Surgery: _____

Diagnosis + Code: _____

Additional Considerations/Precautions: _____

_____

____ Voice Evaluation with Videostroboscopy
____ Voice Evaluation without Videostroboscopy
____ Videostroboscopic Evaluation only
____ Speech / Voice Therapy (including gender affirming services)
____ LSVT LOUD or PhoRTE treatment for Parkinson Disease
____ Dysphagia Evaluation with Fiberendoscopic Evaluation of Swallowing (FEES)
____ Dysphagia Therapy
____ Evaluation for prescription of speech generating device (AAC)
____ Speech and Language or Cognitive Communication Evaluation
____ Motor Speech Evaluation

Physician Signature: _____ Referral Date: _____

Physician Name: _____

Phone: _____ Fax: _____

*Please include any relevant medical records with this form.