

Physician Referral Form

Fax to: Dr. Bonnie Smith
VoiceSpeechStudio.com
Fax: (941) 764-6869
Phone: (941) 769-1026

Patient Name: _____

Patient Age: _____ Birthdate: _____

Patient Diagnosis: _____

Diagnosis code(s): _____

This patient is being referred for a speech evaluation (CPT 92506) and 5-8 speech therapy sessions (CPT 92507) are being ordered for this patient. These are approximately one hour each and will occur at intervals determined by Dr. Smith, the speech pathologist seeing this patient. These sessions are an essential part of this patient's speech improvement process and provide treatment/benefits which will not be achieved by either medical or surgical management.

Physician Name (please print): _____

Physician Signature: _____

Physician Phone Number: _____

Date: _____