Otolaryngologist 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 voice evaluation (CPT 92506) and 5-8 voice 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/voice therapist seeing this patient. These sessions are an essential part of this patient's voice restoration process and provide treatment/benefits which will not be achieved by either medical or surgical management, alone.

Physician Name (please print):_____

Physician Signature:_____

Physician Phone Number:_____

Date:_____