

## Physician Referral for Speech-Language Pathology services

**Referral to: Columbia Speech Therapy Services**

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**Physicians:** Thank you for referring your patient to Columbia Speech Therapy Services (CSTS).

To expedite the referral process please complete the form below and fax it to our office. If you prefer, you may include or substitute your standard referral/prescription form and patient ID label. Following our initial evaluation a written Treatment Plan will be sent to your office.

Physician: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Patient:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Contact (if other than patient):** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Medical Dx (for current SLP referral):** \_\_\_\_\_

**Additional Comments:** \_\_\_\_\_

**Speech-Language Pathology services requested by physician:**

\_\_\_\_\_ Screening                      \_\_\_\_\_ Evaluation only                      \_\_\_\_\_ Evaluation & Treatment

**Contact arrangements:**

\_\_\_\_\_ Columbia Speech Therapy Services will contact patient. (*preferred*)

\_\_\_\_\_ Patient will contact Columbia Speech Therapy Services.

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