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.