Speech Therapy Prescription

Patient Name: ______________________________D.O.B: _______________Date:__________

Parent's Name: ______________________________Phone Number: ______________________

Referring Physician: _________________________ Office Number: _______________________

☐ Speech Therapy Evaluate and Treat as Necessary

Medical Diagnoses (if applicable): ____

Speech Modalities:

☐ Feeding/Oral Motor
☐ Cognition
☐ Language
☐ Articulation
☐ Augmentative Communication
☐ Fluency
☐ Voice
☐ Auditory Verbal
☐ Literacy
☐ Auditory Processing
☐ Comprehensive Speech and Language

Speech Therapy Diagnostic Code: ____

☐ Special Instructions/Other: ____

Physician Signature: ________________________________Date:__________ Time: _________

NPI# ____

FAX ALL THERAPY PRESCRIPTIONS TO: 757-668-7389