



REFERRAL FOR OUTPATIENT **HEAD AND NECK SPEECH PATHOLOGY**

FAX to (212) 263-0113

Date: _____

Patient Name: _____

Patient Date of Birth: _____ Patient Social Security Number: _____

Parent/Guardian Name (if appropriate): _____

Patient / Guardian Telephone Number: Contact 1: (____)____-_____

Contact 2: (____)____-_____

PLEASE NOTE: If patient cannot be contacted directly, with whom should we speak? _____

Patient Address: _____

Primary Language: _____

Primary Insurance: _____ Policy Number: _____ Insured Name: _____

Secondary Insurance: _____ Policy Number: _____ Insured Name: _____

Medical Diagnosis: _____

Onset Date: _____

____ Voice disturbance/dysphonia (784.49) ____ Dysphagia (787.20)

____ Vocal cord paralysis/paresis (478.30) ____ Dysarthria (784.5)

____ Paradoxical vocal fold dysfunction (478.75)