

NW Speech Therapy, LLC.  
Building Better Ways to Communicate

**PEDIATRIC Speech Therapy Referral Form**

Please make referrals to our clinic and we will schedule with an appropriate therapist.

Patient's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Parent's Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Insurance: \_\_\_\_\_

ICD-9 Code:

- 784.5 – Speech Disturbance (other)
- 784.6 – other symbolic dysfunction (excludes developmental learning delays)
- 784.69 – Childhood Apraxia of Speech
- 307.0 – Stuttering/stammering
- 389.0 - conductive hearing loss
- 787.2 – Dysphagia/ Difficulty Swallowing
- 784.4 – Voice disturbance
- 299.0 – Autism, PDD NOS
- Other: (please list # and description) \_\_\_\_\_

**SERVICES:**

**Speech-Language Pathology**

\_\_\_\_ Evaluation / Treatment      \_\_\_\_ Evaluation Only      \_\_\_\_ Other \_\_\_\_\_

Authorized # of visits: \_\_\_\_ to be completed within: \_\_\_\_ week(s)/month(s)

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print name: \_\_\_\_\_  
Clinic Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Please fax this form and chart notes to:

NW Speech Therapy  
Fax #: 1-888-844-0883  
Phone #: 503-512-9355 (Oregon); 360-747-7144 (Vancouver, WA)