1801 E 51st, Ste. 365 #239
Austin, TX 78723
Tel: (512) 661-7971
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Cascada Resilient Therapy

Physician Referral Form for Pediatric Speech Therapy

Patient's Name: _____ Date of Referral: _____

Date of Birth: _____

Diagnosis: _____

Parent/Guardian: _____ Phone: _____

Reason for Referral: _____

_____

ICD-10 Code:

- ☐ R47.49—other speech disturbance
- ☐ F80.0—articulation/phonology disorder
- ☐ F80.1—expressive language disorder
- ☐ F80.2—mixed receptive-expressive language disorder
- ☐ F80.4—speech & language delay due to hearing loss (chronic ear infection)
- ☐ F80.81—childhood onset fluency (stuttering) disorder
- ☐ R49.8—other voice and resonance disorders
- ☐ R13.11—oral dysphagia
- ☐ R63.3—feeding difficulties
- ☐ Other: (please list # and description) _____

SERVICES:

(please circle)	Speech-Language Pathology	Feeding/Swallowing
(please circle)	Evaluation / Treatment	Evaluation Only
(please circle)	Frequency: 1 2 3 4 5 days/week for 6 12 months	

Physician's Signature: _____ Date: _____

Print name: _____ NPI #: _____

Clinic Name: _____ Phone number: _____

Additional Comments: _____

_____

Please fax this form to: (512) 379-0249