THE SPEECH & HEARING CENTER

Physician Referral Form

Referring Physician: _____ Date: _____

Physician's Office: _____

Office Phone #: _____ Office Fax #: _____

Patient Name: _____ Date of Birth: _____

Patient Primary Language (Please Circle): **English** **Spanish** **Other**: _____

Patient Primary Insurance: _____

Parent/Contact Name: _____ Relation to Patient: _____

Parent/Contact Phone Number: _____

With all referrals please attach any available H&P/HPI, indications for evaluation, & insurance info

Referral for (Please Check):

Speech-Language Pathology Services:

◯ Speech-Language Evaluation & Treatment

Physical Therapy Services:

◯ Physical Therapy Evaluation & Treatment

Occupational Therapy Services:

◯ Occupational Therapy Evaluation & Treatment

Audiology Services:

◯ Diagnostic Hearing Evaluation

NOTE: *by signing the referral for a diagnostic hearing evaluation, I the undersigned provider, attest to having visually inspected the patient's ears for physical obstruction.*

◯ Non-Sedative Auditory Brainstem Response (ABR) Hearing Screening

Additional Comments:

Physician Signature: _____ Date: _____

FAX REFERRALS TO 423-622-4834.

You will receive a fax from us in return when patient has been scheduled.

2212 Encompass Drive, Suite 148, Chattanooga, TN 37421
Phone: 423-622-6900 | Fax: 423-622-4834
www.SpeechHearing.com