Blue Water Voice
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Speech Therapy Referral Form

Patient's Name ____ DOB_____________

Patient's Phone __________________________________

Diagnosis: (Choose all that apply)

- ☐ Dysphonia: R49.0
- ☐ Chronic Cough: R05.3
- ☐ Irritable Larynx Syndrome: J38.7
- ☐ PVFM/VCD: J38.5
- ☐ Laryngospasm: J38.5
- ☐ Other _____________

Special Instructions/Precautions:

____

Please include medical history and videostroboscopy/laryngoscopy report with this referral.

Recommended Service: Voice Evaluation and Treatment

____ _____________________
Physician Signature Referral Date

____
Physician Name (Printed)

__________________________________ __________________________________
Physician Phone Physician Fax

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