



Blue Water Voice LLC  
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## Speech Therapy Referral Form

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient's Phone \_\_\_\_\_

Diagnosis: (Choose all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Dysphonia: R49.0                 | <input type="checkbox"/> Dysphagia, oral phase: R13.11          |
| <input type="checkbox"/> Chronic Cough: R05.3             | <input type="checkbox"/> Dysphagia, oropharyngeal phase: R13.12 |
| <input type="checkbox"/> Irritable Larynx Syndrome: J38.7 | <input type="checkbox"/> Dysphagia, pharyngeal: R13.13          |
| <input type="checkbox"/> PVFM/VCD: J38.5                  | <input type="checkbox"/> Other _____                            |
| <input type="checkbox"/> Laryngospasm: J38.5              |   |
| <input type="checkbox"/> Dysphagia, unspecified: R13.10   |   |

### Special Instructions/Precautions:

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

### Recommended Service:

- |   |  |
|---|--|
| <input type="checkbox"/> Voice Evaluation and Treatment | <input type="checkbox"/> Swallowing Evaluation and Treatment |
|   | <input type="checkbox"/> Other _____                         |

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Referral Date

\_\_\_\_\_  
Physician Name (Printed)

\_\_\_\_\_  
Physician Phone

\_\_\_\_\_  
Physician Fax

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