NYU Rusk Institute of Rehabilitation Medicine
NYU LANGONE MEDICAL CENTER

REFERRAL FOR OUTPATIENT **HEAD AND NECK SPEECH PATHOLOGY**

FAX to (212) 263-0113

Date: _____

Patient Name: _____
Patient Date of Birth: _____ Patient Social Security Number: _____
Parent/Guardian Name (if appropriate): _____
Patient / Guardian Telephone Number: Contact 1: (_____)_____-_____
Contact 2: (_____)_____-_____
PLEASE NOTE: If patient cannot be contacted directly, with whom should we speak? _____
Patient Address: _____
_____
Primary Language: _____
Primary Insurance: _____ Policy Number: _____ Insured Name: _____
Secondary Insurance: _____ Policy Number: _____ Insured Name: _____

Medical Diagnosis: _____
Onset Date: _____

_____Voice disturbance/dysphonia (784.49)
_____Vocal cord paralysis/paresis (478.30)
_____Paradoxical vocal fold dysfunction (478.75)
_____Total laryngectomy/aphonia (784.41)
_____Vocal fold lesion/benign (478.5)
_____ Dysphagia (787.20)
_____ Dysarthria (784.5)
_____ CA tongue (141.8)
_____ CA larynx (161.9)
_____ CA tongue base (146.8)
Other (specify) _____

Prescription for: (please select)
_____Evaluation only _____Evaluation and Treatment

***Type of Evaluation**:

Speech evaluation (92506)	_____	Laryngeal function study (92520)	_____
Clinical Swallow evaluation (92610)	_____	Modified Barium Swallow procedure (92611)	_____
Evaluate Voice Prosthesis/TEP (92597)	_____	Evaluate Electrolarynx (92607)	_____

Speech and Language Diagnosis: _____dysphonia _____dysphagia _____dysarthria _____aphonia/TL _____Other

Physician Order Frequency and Duration: _____ _____
(times/week) (number of months)

Physician's Name (Please Print): _____
License Number: _____ UPIN: _____ NPI: _____
Office Telephone: _____Office Fax: _____
Physician's Signature: _____