



RUSK INSTITUTE of Rehabilitation Medicine

REFERRAL FOR OUTPATIENT ADULT SPEECH / LANGUAGE PATHOLOGY

FAX to the RUSK BUSINESS OFFICE (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: _____

ICD9: _____

Onset Date: _____

- ____ CVA
- ____ Parkinson's Disease
- ____ Degenerative disease of the basal ganglia
- ____ Spinocerebellar disease
- ____ Vocal cord paralysis
- ____ Other laryngeal diseases of the vocal cords
- ____ Unspecified CV disease
- ____ Other _____

- ____ TBI
- ____ ALS
- ____ Multiple Sclerosis
- ____ Pseudobulbar palsy
- ____ Encephalitis
- ____ Anoxic Brain Injury
- ____ Brain Tumor

Prescription for: (please select)

____ Evaluation only

____ Evaluation and Treatment: _____
(times/week) (number of months)

Speech and Language Diagnosis:

- ____ Aphasia 784.3
- ____ Cognitive communication disorder 438.0
- ____ Voice disorder 784.4
- ____ Other _____
- ____ Dysarthria (motor speech disorder) 784.5
- ____ Alexia, agraphia 784.61
- ____ Stuttering (fluency disorder) 307.0

Please visit www.nyuvoicecenter.org for Head and Neck SLP referrals

Physician's Name (Please Print): _____

License Number: _____ UPIN: _____ NPI# _____

Office Telephone: _____ Office Fax: _____

Physician's Signature: _____

