



RUSK REHABILITATION

REFERRAL FOR OUTPATIENT PEDIATRIC SPEECH / LANGUAGE PATHOLOGY

Fax to the RUSK INSTITUTE (212) 263-4555

Call the Department of Pediatric Speech-Language Pathology (212) 598-6248

Date: _____

Patient Name: _____ Sex: M F

Patient Date of Birth: _____

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: _____

ICD10: _____

Onset Date: _____

- CVA
- Cerebral Palsy
- Spina Bifida
- PDD/ASD
- Encephalopathy
- Other _____

- TBI
- Seizure Disorder
- Multiple Sclerosis
- Brain Tumor
- Developmental Delay

Prescription for: (please Select)

Evaluation only Evaluation and Treatment AT- Communication Assessment

Speech and Language Diagnosis

- Aphasia
- Cognitive Communication Disorder
- Voice Disorder
- Other _____
- Dysarthria (Motor Speech Disorder)
- Apraxia (Motor Speech Disorder)
- Speech and Language Deficits
- Articulation Disorder

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: _____

NYU Langone Orthopedic Hospital

NYU Rusk Rehabilitation

301 East 17th Street, 4th Floor, New York, NY 10003 • Tel 212.598.6248 • Fax 212.263.4555