IDAHO SPEECH & SWALLOW SERVICES

801 N Stilson Rd. STE 130, Boise, ID 83703
P: 208-996-0828 I F: 208-908-0031
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REFERRAL FORM

Name:_____

Patient Phone (s):_____

Diagnosis(es):_____ ICD Code(s): _____

Services (Specify):

- ☐ Expressive or Receptive Language (Aphasia) Therapy
- ☐ Voice Dysarthria Therapy
- ☐ Speech/Dysarthria Therapy
- ☐ Swallowing (Dysphagia) Therapy/Flexible Endoscopic Evaluation of Swallow (FEES)
- ☐ Cognitive-Communication
- ☐ Orofacial myofunctional therapy (OMT)
- ☐ Other SLP Therapy:

Treatment Specifics: _____

Precautions: _____

- ☐ Evaluate and Treat as indicated, or
- ☐ Frequency & Duration of Treatment:_____

Referring Provider (print/stamp):_____ Phone/Fax:_____

Referring Provider Signature:_____

Date:_____ Time:_____

*Please include pertinent medical history, progress notes, and medication list with referral form. Please fax to 208-908-0031.