REFERRAL INTAKE FORM

Please fax your referral form to Perfekt Me Speech Therapy Services, PLLC at:
Fax: (281) 947-8485 or call us at (832) 736-8485

DATE OF INTAKE:

DISCIPLINE NEEDED: □ SPEECH THERAPY

PATIENT INFORMATION

Patient's Name:	DOB:	Sex: □ Male □ Female
Street Address:	City:	Zip Code:
Guardian's Name:	Relation to Patient:	
Home Phone:	Secondary Phone:	
Cell Phone:	Can we TEXT you? □ Yes □ No	

Email Address:

Primary Language: □ English □ Spanish □ Other____________________________

Patient's Availability: □ All Day □ Mornings □ Afternoons □ After School □ Other:____________________

INSURANCE INFORMATION

Primary Insurance:	Medicaid/Patient ID#:
Secondary Insurance:	Medicaid/Patient ID#:

REFERRAL/PHYSICIAN INFORMATION

Ordering Physician:	Phone:	Fax:
Practice Name:	Contact Name:	
Address:	City:	Zip Code:

TREATMENT INFORMATION

ICD-9/Diagnosis: □ Other ICD-9:________________ Dx:_______________________________

- □ 299.0 Autistic disorder
- □ 299.80 Other specified pervasive developmental disorders; Asperger's disorder
- □ 315.31 Expressive language
- □ 315.32 Mixed receptive-expressive language disorder; Central auditory processing disorder
- □ 315.34 Speech and language developmental delay due to hearing loss
- □ 315.35 Childhood onset fluency disorder
- □ 315.39 Developmental articulation disorder
- □ 783.42 Delayed milestones; Late talker; Late walker
- □ 784.42 Dysphonia; Hoarseness
- □ 784.43 Hypernasality
- □ 784.44 Hyponasality
- □ 784.49 Other voice and resonance disorders
- □ 787.20 Dysphagia, unspecified
- □ 787.21 Dysphagia, oral phase
- □ 787.22 Dysphagia, oropharyngeal phase
- □ 787.23 Dysphagia, pharyngeal phase
- □ 787.24 Dysphagia, pharyngoesophageal phase
- □ 799.51 Attention or concentration deficit
- □ 799.52 Cognitive communication deficit
- □ 799.55 Frontal lobe and executive function deficit

MEDICATIONS:

ARE THERE OTHER SERVICES CURRENTLY BEING PROVIDED? □ Yes □ No REFERRED BY:

WERE THERE OTHER SPEECH THERAPY SERVICES PROVIDED IN THE PAST? □ Yes □ No

PERSON COMPLETING INTAKE:

HOMEBOUND STATUS: □ Unable to leave the home □ Single parent caretaker □ Multiple children with needs □ Requires assistive device □ Taxing effort to leave home □ Transportation □ Medically fragile □ Funding □ Other____

COMMENTS:

*****FOR PHYSICIAN'S ORDERS OTHER THAN PRESCRIBED ON THE 485 PLAN OF CARE:**

PHYSICIAN'S NAME:____

PHYSICIAN'S SIGNATURE:____ DATE:_________