POSITIVE OUTLOOK, INC. SPEECH-LANGUAGE SERVICES
696 Mt. Zion Road • Suite 3B • Jonesboro • GA 30236
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Pediatric Speech Therapy Referral Form

PATIENT'S NAME:
DATE OF BIRTH:
PARENT'S NAME:
PHONE:
PRIMARY DIAGNOSIS:_____
CONCERNS: Speech Language Delays
INSURANCE:

ICD-9 CODE: Please list or check any Primary and/or Speech-Language Diagnosis

___ 784.69 Childhood Apraxia of Speech
___ 787.2 Dysphagia/Difficulty Swallowing
___ 299.0 Autism, PDD NOS
___ 315.39 Other Developmental Speech Disorder
___ 343.9 Infantile Cerebral Palsy Unspecified
___ 382.9 Otitis Media Unspecified
___ Other: (please list # and description)

___ 784.6 Other Symbolic Dysfunction
___ 389.0 Conductive Hearing Loss
___ 784.4 Voice Disturbance
___ 315.32 Mixed-Receptive Language Disorder
___ 314.01 ADD

Service:

Speech-Language Pathology
___ Evaluation/Treatment ___ Evaluation Only ___ Other _____

Hearing Screening Results:

__ Attached Copy of Hearing Screening

__ Not Available Reason: _____

Authorized # of visits: ____ to be completed within: ____ week(s)/month(s)

Physician's Signature: _____ Date: ____/____/____

Print Name: _____

Clinic Name: _____ Phone Number: (____)_____-_____

Please make referrals to our clinic and we will schedule with an appropriate therapist