emerald city therapies

PCP Referral Form

Patient Name: ____ Date: __________________________

Parent/Guardian: ____ Phone: __________________________

Referring Physician: ______________________________________ Phone: __________________________

Diagnosis: ____

Insurance: ____

Reason for Referral: ____

SPEECH THERAPY		OCCUPATIONAL THERAPY	
❐ F84.0	*Autism*	❐ R63.3	*Feeding Difficulties*
❐ F80.1	*Expressive Language Disorder*	❐ G54.0	*Brachial Plexus Disorders*
❐ F80.2	*Mixed Receptive/Expressive Lang. Disorder*	❐ R62.0	*Delayed Milestones in Childhood*
❐ F80.4	*Speech & Language Delay due to hearing loss*	❐ G82.20	*Paraplegia, Unspecified*
❐ F80.81	*Childhood Onset Fluency Disorder*	❐ R27.0	*Ataxia, Unspecified*
❐ F80.0	*Phonological Disorder*	❐ F82	*Specific Developmental Disorder of Motor Function*
❐ 169.928	*Speech & Language deficits, unspecified*	❐ M62.81	*Muscle Weakness (generalized)*
❐ R49.9	*Voice & Resonance Disorder*	❐ F88	*Other Disorders of Physiological Development*
❐ R47.89	*Other Speech Disturbance, Unspecified*	❐ M25.60	*Stiffness of Unspecified Joint, not elsewhere classified*
❐ R48.2	*Childhood Apraxia of Speech*	❐ F81.9	*Developmental Disorder of Scholastic Skills, unspecified*
❐ R41.841	*Cognitive Communication Deficit*		*Other:*
❐ R13	*Dysphagia*		
	Other:		

Frequency: __________________ per week Duration: ____________________weeks / months (circle one)

Physician Signature: ____ Date: __________________________

PLEASE FAX TO 469-340-4074. *Thank you for choosing Emerald City Therapies!*

1505 W Jefferson St, Ste 155 | Waxahachie, TX 75165 | p. 214-980-1397 | f. 469-340-4074 | www.emeraldcitytherapies.com