PREMIER
SPEECH & SWALLOWING
SOLUTIONS, LLC.

REFERRAL FORM

Referral Date:________________________ Staff date:_______

Patient Name: __________________________DOB:_________________ Sex:____M ___

Address:________________________________City:______________State:_______Zip: _____
Phone: _________________Ins#:_________________________Ins: ____________

Ethnicity: ____________________(For state and Federal record keeping only)

Parent/Guardian: _____________________Relationship:___________Cell # __________

Services Ordered: **ST** ________________ Is the patient in school? _______________

Diagnosis		Surgical Procedure	ICD9 Code
1. ____________	______	1. ____________	______
2. ____________	______	2. ____________	______
3. ____________	______	3. ____________	______
4. ____________	______	4. ____________	______
5. ____________	______	5. ____________	______
6.		6.	

Referred by: ____________________Address: ______________________

Phone: _______________Fax:_______________Pager: _______________

Physician:____________________Specialty: __________________

Address: _______________City: ___________County: Harris____State: _____Zip:

Phone: ______________________Fax: _______________LIC # __________
NPI# __________

PLEASE FAX REFERRAL TO
(877) 886-0898
Email: intake@premierspeechtx.com
Phone: 281.717.4308