



**Vault with your Voice Speech & Swallowing Services**

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Pronouns: she / her

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Client: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone: \_\_\_\_\_

Alternate phone: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_

Date of Onset/Injury: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_

Special Instructions/Precautions: \_\_\_\_\_

\_\_\_\_ Voice Evaluation (CPTs 92524 + 92520)

\_\_\_\_ Cognitive-Communication Evaluation (CPT 96125)

\_\_\_\_ Speech Evaluation (CPTs 92522 + 92520)

\_\_\_\_ Individual Cog-Comm Treatment (CPTs 97129 &

\_\_\_\_ Individual Speech/Voice/Language Therapy (CPT 92507)

97130)

\_\_\_\_ Aphasia Evaluation (CPT 96105)

\_\_\_\_ Clinical Swallow Evaluation (CPT 92610)

\_\_\_\_ Dysphagia Therapy (CPT 92526)

Physician Signature: \_\_\_\_\_

Referral Date: \_\_\_\_\_

Physician Name (print): \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

***Please attach relevant medical records including: relevant hospital records, imaging (MBSS, Chest XR, Barium Swallow Studies, Head CT/MRI reports), most recent consults with ENT (including laryngoscopy results), Gastroenterology, Neurology, Pulmonology, head/neck surgery records, GERD/LPR work-up, current medications, previous speech therapy or modified diet recommendations. Thank you!***

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