THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER
Department of Audiology and Speech Pathology

Hearing and Speech Center (UTK Campus)
1600 Peyton Manning Pass
Knoxville, TN 37996-2500
Phone: 865-974-5451
FAX: 865-974-4639

NEW PATIENT REFERRAL FORM - *SPEECH-LANGUAGE*

Revised 6/2017

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Male/Female

Parent/Spouse/Guardian: _____

Address: _____City: _____State: ___Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PURPOSE OF REFERRAL [ ] Evaluation (including a hearing evaluation, if indicated)
[ ] Treatment

PLEASE NOTE: This referral is effective for *one year* from the date a properly completed and signed form is received. Our center will send requests to update referrals annually on established patients.

AREAS OF CONCERN (check any that apply)

[ ] Speech [ ] Reading [ ] Traumatic Brain Injury [ ] Stuttering [ ] Apraxia [ ] Autism
[ ] Language [ ] Voice [ ] Feeding/Swallowing [ ] Aphasia [ ] Cognition

ADDITIONAL PROCEDURES [ ] Stroboscopy (Voice) [ ] Swallowing Evaluation: Fiberoptic Endoscopic Evaluation of Swallowing (FEES)

PERTINENT MEDICAL HISTORY with ASSOCIATED ICD-10 DIAGNOSIS CODE/S _____

_____

PROVIDER INFORMATION

Referring Physician: _____
Address: _____
Phone #: _____Fax #: _____
Provider's NPI:_____
Primary Care Provider: _____
Phone #: _____Fax #: _____
Provider's NPI: _____

- Before we can schedule your patient and bill for insurance we must have the referring provider's NPI.
- Please also send ***all*** relevant medical notes or test results

Is this patient currently receiving home healthcare services?

[ ] No [ ] Yes List Provider _____

INSURANCE INFORMATION

Primary Carrier:_____
Subscriber ID#: _____ Group #: _____
Secondary Carrier: _____
Subscriber ID#: _____ Group #: _____
Is a pre-cert or authorization number Required? Yes or No
Authorization/pre-cert #: _____# of visits: _____
Dates visits are valid: _____

AND

- Send a copy of the patient's insurance card/s (front and back)

Referring Provider's Signature (Required): _____ Date: _____