TheraVolve Wellness Co.
Vanessa Alcala, M.S. CCC-SLP
4125 Gunn Hwy Ste B1
Tampa, FL 33618
Phone: (813) 778-5682
Fax: (813) 761-0950

Speech Therapy Referal Form

www.theravolvewellness.com

Patient: _____ Date of Birth: _____

Phone: _____ Alternate Phone: _____

Diagnosis: _____ Diagnosis Code: _____

Date of Onset/Injury: _____ Date of Surgery: _____

Special Instructions/Precautions: _____

_____

Choose the evaluation/treatment that best fits your patient's needs.

- ☐ Evaluation of Speech Sound Production; with evaluation of language comprehension and expression (92523)
- ☐ Voice Evaluation with Laryngeal Function Studies (92524 and 92520)
- ☐ Clinical Swallow Evaluation (92610)
- ☐ Swallowing Therapy (92526)
- ☐ Assessment of Aphasia (96105)
- ☐ Evaluation of Speech Fluency (92521)
- ☐ Speech Therapy (92507)

Physician Findings: _____

Physician Signature: _____ Referral Date: _____

Physician Name (Print): _____

Physician Phone: _____ Fax: _____

When signed by a physician, this form acts as a prescription for therapy services. Please fax this form along with any relevant medical information to (813) 761-0950.