

Idaho Face & Voice

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Patient Name _____ DOB _____

Patient Phone(s) _____

Diagnosis _____ ICD-10 Code _____

Services (Specify)

- ☐ Voice Therapy
- ☐ Breathing Retraining
- ☐ Cough Suppression/Throat Clear Suppression Therapy
- ☐ Globus Pharyngeus Behavioral Management
- ☐ Irritable Larynx, Reflux Management
- ☐ Facial Neuromuscular Retraining (fNMR)
- ☐ Esophageal Dysphagia Management
- ☐ Concussion Management
- ☐ Stuttering Therapy (teens/adults)
- ☐ Other SLP Therapy _____

Treatment Specifics _____

Precautions _____

- ☐ Evaluate and Treat, as indicated, or
- ☐ Frequency & Duration of Treatment _____

Referring Provider (print/stamp) _____ Phone _____

Referring Provider Signature _____

Date _____ Time _____

**Please include Patient Demographics and recent office visit notes*

Thank you for your referral!