COLORES SPEECH

SPEECH THERAPY PRESCRIPTION & REFERRAL FORM

Patient's Name:_____ Date of Birth: _____
Contact Name:_____ Phone No.: _____

Commonly Used ICD-10 Codes (Check all that apply)

☐	F80.0 – Phonological processing disorder / Articulation disorder
☐	F80.1 – Expressive language disorder
☐	F80.2 – Mixed receptive-expressive language disorder
☐	F80.4 – Speech and language developmental delay due to hearing loss
☐	F80.89 – Other developmental disorders of speech and language
☐	Q90.9 – Down Syndrome, unspecified
☐	R13.10 – Dysphagia, unspecified
☐	R41.841 – Cognitive communication deficit
☐	R48.2 – Apraxia
☐	R48.8 – Other symbolic dysfunction (secondary to a neurological condition)
☐	R49.9 – Unspecified voice and resonance disorder
☐	R63.3– Feeding difficulties

Conditions Commonly Associated with Treatment of Pediatric Patients

☐	F80.81 – Childhood onset fluency disorder (Stuttering/Cluttering)
☐	F84.0 – Autistic disorder
☐	R62.0 – Delayed milestone in childhood
☐	R62.5 – Other and unspecified lack of normal physiological development in childhood

Conditions Commonly Associated with Treatment of Adult Patients

☐	I69.91 – Cognitive deficits following unspecified cerebrovascular disease
☐	I69.920 – Aphasia following unspecified cerebrovascular disease
☐	R47.1 – Dysarthria and anarthria

Other: (please list any specific ICD-10 Code and description)

_____

Speech-Language Pathology Service(s)

☐ Evaluation / Treatment Evaluation Only ☐

Physician's/Clinician's Signature: _____ Date:_____
Physician's/Clinician's Printed Name: _____ NPI#: _____

When signed by a physician, this form acts as a prescription for therapy services.
Please fax this form along with any additional relevant medical information to 612-545-4938.

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