Altruistic
THERAPY SERVICES

Referral / Script - Speech Language Swallowing /Cognitive

****If this is a first time referral from your office, please send patient demographics and any pertinent testing related to this referral.****

Patients Name: _____ Date:_____

Patient DOB: _____ Medical Diagnosis:_____

Patient to be seen ____times per week, for _____ min / hour per session for_____ months.

Please check all that apply:

Evaluate and treat for:

- ☐ **Swallowing Difficulty / PO tolerance**
- ☐ Oral Dysfunction
- ☐ Pharyngeal Dysfunction
- ☐ Laryngeal Dysfunction
- ☐ Upper Esophageal Sphincter (UES) Dysfunction
- ☐ Weight Loss
- ☐ Training in feeding guidelines
- ☐ NMES (Neuromuscular electrical stim)

- ☐ **Cognition**
- ☐ Safety Awareness
- ☐ Recall / Insight / Awareness
- ☐ Self – Assessment
- ☐ Attention
- ☐ Memory
- ☐ Problem solving
- ☐ Executive functioning

- ☐ **Voice**
- ☐ Phonation quality
- ☐ Pitch
- ☐ Loudness
- ☐ Breath support for Voice
- ☐ Alaryngeal Voice
- ☐ LSVT- Lee Silverman Voice Training

- ☐ **Speech**
- ☐ Oral motor weakness
- ☐ Articulation, Motor planning. Phonology
- ☐ Breath support / diaphragmatic tx for speech and voice

- ☐ **Language**
- ☐ Spoken and written language (listening, processing, speaking, reading, writing, pragmatics)
- ☐ Phonology, Morphology, Syntax, Semantics
- ☐ Pragmatics (language use, behavioral, social aspects of communication)
- ☐ Prelinguistic communication (e.g., joint attention, intentionality, communicative signaling)
- ☐ Paralinguistic communication (e.g., gestures, signs, body language)
- ☐ Literacy (reading, writing, spelling)

- ☐ **Assess for the need of speech services only:**
- ☐ Swallowing
- ☐ Cognitive function
- ☐ Voice
- ☐ Speech
- ☐ Language

Physician Signature:_____
NPI:_____

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