CHICO SPEECH AND LANGUAGE CENTER

2627 Forest Avenue
Chico, CA 95928
(530) 894-0702 Fax (530) 894-0905

Prescription Order

Patient Information

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Primary Language: _____

Name of Guardian (if client is a minor): _____

Insurance Information

Insurance Company: _____

Policy Number: _____

Patient is Referred For: (Please check)

_____Speech and Language Evaluation
_____Ongoing Speech and Language Therapy

_____Myofunctional Evaluation
_____Ongoing Myofuntional Therapy

_____ Feeding Evaluation
_____Ongoing Feeding Therapy

_____Occupational Evaluation
_____Ongoing Occupational Therapy

_____ AAC Device Evaluation
_____AAC Device Ongoing Therapy

Brief Description of the Problem:_____

Diagnosis and Service Code:_____

Report Requested: Yes: _____ No: _____

Please Mail or Fax Report To: _____

Referred By: _____

(Please Print Name and Place) **Doctor NPI:** _____

Phone Number:_____ **Fax Number:** _____

_____

Signature of Referral Source