

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	_____ Myofunctional Evaluation
_____ Ongoing Speech and Language Therapy	_____ Ongoing Myofunctional Therapy
_____ Feeding Evaluation	_____ Occupational Evaluation
_____ Ongoing Feeding Therapy	_____ Ongoing Occupational Therapy
_____ AAC Device Evaluation	_____ Physical Therapy Evaluation
_____ AAC Device Ongoing Therapy	_____ Ongoing Physical 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