Provider Referral Form

CLIENT INFORMATION - PEDIATRIC

Notice Regarding Electronic Communication and HIPAA Compliance

All referral information submitted electronically via email **must be sent from a protected, HIPAA-compliant server** to ensure the privacy and security of patient health information. Please note that **all** email communications from The Speech Spot, LLC are HIPAA-compliant. If you prefer to send referrals via fax, they may be sent securely to: 620-390-2611

Client Information	
Child's Name	
D.O.B.	
Parent/Guardian Name	
Phone	
Email	

Physician Information	
Physician Name	
NPI #	
Office/Clinic Name	
Office/Clinic Address	
City/State	
Phone	
Fax	

Referral Reason

☐	Speech/Language Evaluation	☐	Speech/Language Treatment
Area(s) of Concern or Need			
☐	Speech Sounds (Intelligibility)	☐	Stuttering/Fluency
☐	Language (Spoken and/or Receptive)	☐	Social Skills
☐	Attention/Concentration?	☐	Alternative Communication (AAC)
☐	Hearing Impairment	☐	Voice?
☐	Learning Disability (dyslexia/literacy)?		

Comments:

Provider Signature: _____

Date: _____

The Speech Spot, LLC

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