HELPING HANDS
PEDIATRIC THERAPY SERVICES

Speech Therapy Referral Form

Patient Name: _____ Patient's DOB: _____/_____/_____

Parent/Caregiver Name: _____ Phone Number: _____

Primary Language Spoken at Home: _____

Reason for Referral (Check all that apply):

__ Articulation problems __ Child has changes in their communication or cognition following an injury or surgery __ Child has stopped saying sounds or words (s)he had previously mastered __ Child has unintelligible speech after 24 months of age and cannot be understood by those who do not know the child well __ Cognitive changes (ie. decreased memory or problem solving skills) __ Cognitive or other developmental delays __ Difficulty following 2-3 step directions __ Difficulty playing with toys appropriately __ Difficulty sucking or drinking from a cup __ Difficulty swallowing liquids or solids (ie. choking, gagging, etc.) __ Difficulty taking foods from a spoon or chewing foods __ Feeding and swallowing disorders	__ Fluency disorders __ Has difficulty communicating basic needs __ Has difficulties following commands __ Has difficulty or is not responding to directions, questions, or conversations with others __ Hearing impairment __ Making only a few or poor quality sounds __ Not combining words by 24 months of age __ Not speaking in sentences by 36 months of age __ Slow to show an understanding of new words __ Struggles to imitate the sounds made by others __ Struggles to or is not able to start conversations with others __ Traumatic brain injury __ Weak oral muscles

Patient also has issues in the following/or is undergoing:

__ ADHD or ADD __ Augmentative and Alternative Communication Device (Does the child currently use one?) __ Autism Spectrum or PDDNOS __ Auditory Processing __ Behavioral Issues __ Cerebral Palsy __ Chromosomal/Genetic Disorder (Please specify: _____) __ Chronic Ear Infections __ Cleft Lip or Palate	__ Fine Motor Difficulties __ Gross Motor Difficulties __ Neurological __ Nutritional (Dietary or Taste) Difficulties __ PANDAS __ Play Skills: Does the child play alone or with others? __ Play Skills: Does the child understand use of common objects? __ Premature Birth (How many weeks? _____) __ Other _____

Patient Name: _____ Patient's DOB: _____/_____/_____

Parent/Caregiver Name: _____ Phone Number: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Has child received therapy services prior to this referral? _____ YES _____ NO

If yes, when? _____ If yes, where? _____

Helping Hands, Inc. accepts the following insurances: Aetna HMO/PPO, Anthem BCBS, Anthem BCBS Federal Employee Plan, CareFirst BCBS, Cigna, Kaiser Permanente, Tricare Standard and Prime, and Virginia Premier HMO.

Primary Insurance Coverage for Child: _____

ID # _____ Group # _____

Effective Date: _____ 1-800 # from Back of Card: _____

Policy Holder: _____ Policy Holder's DOB: _____ Relation to Patient: _____

Secondary Insurance Coverage for Child: _____

ID # _____ Group # _____

Effective Date: _____ 1-800 # from Back of Card: _____

Policy Holder: _____ Policy Holder's DOB: _____ Relation to Patient: _____

Helping Hands, Inc. will send a copy of the evaluation conclusion and proposed treatment plan to the ordering physician before therapy is initiated. Please be sure to provide us with the following information:

Referring Physician's Name: _____ Date: _____

NPI # _____

Phone Number: _____ Fax Number: _____

Thank you in advance for referring your patient to us. Please note, new patient appointments are typically scheduled 2-3 months from the initial inquiry. If you have questions, please be sure to contact us at 540-657-1423.