

NEW PATHS FOR HEALTH

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REFERRAL FORM

Patient Name: _____ DOB: _____

Parent/Guardian: _____ Phone: _____

Referring Provider: _____ Date: _____

Provider Phone: _____ Fax: _____

SPEECH THERAPY REFERRAL

Diagnosis / Reason for Referral:

- F80.0 Phonological Disorder
- F80.1 Expressive Language Disorder
- F80.2 Mixed Receptive-Expressive Language Disorder
- F80.4 Speech and Language Development Delay Due to Hearing Loss
- R13.10 Dysphagia, Unspecified

- R41.841 Cognitive Communication Disorder
- R47.1 Dysarthria/Aphasia
- Other: _____

Requested Services:

- Speech Evaluation
- Speech Therapy Treatment
- Evaluate and Treat

NEUROFEEDBACK REFERRAL

Referral Concerns / Symptoms:

- Impulsivity
- Difficulty with Focus or Concentration
- Emotional Dysregulation
- Excessive Stress or Worry
- Sleep Difficulties
- Mental Fatigue / Brain Fog
- Executive Functioning Difficulties
- Self-Regulation Challenges
- Irritability
- Performance Anxiety

- Headaches / Migraines
- Concussion Recovery Support
- Peak Performance
- Other: _____

Requested Services:

- QEEG Brain Mapping Evaluation
- Neurofeedback Training
- Neurofeedback Consultation
- Please Evaluate and Recommend Services

Additional Notes:

Provider Signature: _____ Date: _____