



# The Charity League Hearing and Speech Center

## Referral for Hearing and/or Speech/Language/Feeding Evaluation

**If using Epic, this form is not required.**  
Please enter Ambulatory Referral to Speech and/or Audiology

**Physician Office Instructions:** Please fax to our Scheduling Office at (205)638-3680.

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent(s): \_\_\_\_\_ Cell Phone(s): \_\_\_\_\_

Parent Email Address: \_\_\_\_\_

Referring Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

FAX: \_\_\_\_\_

**\*Ambulatory Referral to Audiology:**

- Hearing test
- Vestibular evaluation

**\*Ambulatory Referral to Speech-Language Pathology:**

- Speech/language evaluation & treatment
- Feeding evaluation & treatment
- Feeding evaluation & treatment with Modified Barium Swallow Study
- Modified Barium Swallow Study (return patients only)

**\*Reason for Hearing/Audiology:**

- failed hearing test in office/at school
- failed newborn hearing screen
- parent/teacher concern of hearing loss
- recurrent and/or chronic ear infections
- dizziness/ spinning sensation

\*\*\*Children's Audiology does not perform Auditory Processing testing (APD)\*\*\*

other: \_\_\_\_\_

**\*Reason for Speech/Language/Feeding:**

- limited expressive language
- difficulty understanding language
- speech difficult to understand
- limited diet/difficulty chewing solids
- coughing/choking on food/liquids
- history of concussion/brain injury
- stuttering
- cleft palate/resonance
- apraxia of speech/motor planning

other: \_\_\_\_\_

\*Diagnosis (please include ICD-10 code): \_\_\_\_\_

Type of Insurance: \_\_\_\_\_ Insurance Number \_\_\_\_\_

\*Physician signature: \_\_\_\_\_ \*Date: \_\_\_\_\_ \*Time: \_\_\_\_\_

**\*Required**

**Please call Hearing and Speech with questions 205-638-5953**