



Office Use Only: MR identification label

# The Charity League Hearing and Speech Center

**Referral for Hearing and/or Speech Evaluation**  
**Appointments: Call (205) 638-7527**

**Physician Office Instructions: This form must be faxed to the Scheduling Office at (205)638-3680 prior to the patient's appointment.**

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Parent(s) : \_\_\_\_\_ Cell Phone(s): \_\_\_\_\_  
 Primary Email Address: \_\_\_\_\_  
 Referring Physician: (please print) \_\_\_\_\_  
 Referring Physician Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_  
 \_\_\_\_\_ FAX: \_\_\_\_\_

**Please note: Reason for referral, diagnosis and physician's signature are required from the physician's office prior to the patient being seen in the Hearing and Speech Center.**

Patient referred for:

- hearing test
- speech-language evaluation
- vestibular evaluation
- modified barium swallow study

Reason(s) for referral:

*(check any and all that apply)*

- 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
- abnormal resonance or voice
- other (aphasia, apraxia, AAC, etc): \_\_\_\_\_
- limited expressive language
- speech difficult to understand
- feeding/swallowing difficulties
- difficulty understanding language
- history of concussion/brain injury
- stuttering

previously received speech language evaluation    If so, give location and date \_\_\_\_\_  
 previous/present speech language therapy    If so, give location \_\_\_\_\_

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

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

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

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