Referral Form

Cooper & Co. Language and Swallowing Lab, PLLC
Speech, Language, and Swallowing Therapy Services

Patient / Client Information

- Full Name: _____
- Date of Birth: ____ / ____ / _____
- Parent/Guardian (if applicable): _____
- Phone Number: _____
- Address: _____

Referral Details

- Referring Provider/Agency: _____
- Contact Person: _____

- Phone: _____ Fax: _____
- Email: _____

Reason for Referral *(check all that apply)*

☐ Speech Delay / Disorder
☐ Language Delay / Disorder
☐ Feeding / Swallowing Concerns
☐ Voice Disorder
☐ Fluency / Stuttering
☐ Cognitive-Communication Disorder
☐ AAC (Augmentative & Alternative Communication)
☐ Other: _____

Medical / Educational Information

- Diagnoses / ICD-10 (if available): _____
- Physician (if applicable): _____
- School / Facility: _____

Insurance / Funding Information

☐ Medicaid
☐ Private Insurance
☐ Self-Pay
Insurance Provider: _____ ID #: _____

Referring Provider Signature

Signature: _____
Date: ____ / ____ / _____

📌 **Please return completed referral form to:**
Fax: _____
Email:
Phone: _____
