Referral Form

Wala'au Therapy LLC.
Speech/language, Swallowing, and Feeding Therapy
2148 Awapuhi St. Hilo, HI 96720
Phone: 808-365-8128   Fax 808-961-6383

Client Name: ____ **Date of Birth:**_______________

Diagnosis/ICD-10 Code:_______________________________

Primary insurance:_______________________ **Insurance ID Number:**__________________

Parent/Guardian Name:____

Phone____ **Email:**_________________________

Address:____

Common diagnosis:

Speech/language therapy: Aphasia, Cognitive Communication Deficit, Right Hemisphere Syndrome, Voice disorder, Developmental Delay of Speech and Language, Fluency disorder, Autism Spectrum Disorder, Cerebral Palsy, Articulation/Phonological Disorder, Down Syndrome, Mixed Expressive and Receptive Language Disorder, Apraxia of Speech, Social Pragmatic Communication Disorder

Swallowing/Feeding therapy: Dysphagia. Cerebrovascular Accident (CVA), Parkinson's Disease, Pediatric Feeding Disorder, Autism Spectrum Disorder, Cerebral Palsy, Down Syndrome, Oral Motor Delay, Feeding Difficulties

Reason for referral:____

Referring client for:

________ Speech/Language Evaluation/treatment

________Swallowing/Feeding Evaluation/therapy

Referring Agency/Physician: ____

Phone:____ Fax: ___________________________

Physician Signature: _________________________________ Date: ____________________