614-808-3563 • premierspeechohio.com
3803 Attucks Drive, Suite A • Powell, OH 43065

"Our Help Speaks Louder Than Words"

Speech-Language Therapy Referral/Prescription

Patient Name: _____

DOB: _____

Date: _____

Phone: _____

Diagnosis: _____

Service(s) Requested (check all that apply):

- ☐ Evaluation and Treatment of Speech/Language
- ☐ Evaluation and Treatment of Cognitive-Communication
- ☐ Evaluation and Treatment of Dysphagia/Feeding Aversion
- ☐ Other (please specify): _____

I hereby certify the medical necessity of the services listed above.

Physician Name: _____

Physician Signature: _____

Physician Phone: _____

Practice Name: _____

Physician NPI: _____

FAX ALL THERAPY PRESCRIPTIONS TO: 614-808-3563