Kokua Therapy Services, LLC
P: (808) 384-8328
sarah@kokuatherapy.com

PHYSICIAN FAX REFERRAL FORM
PEDIATRIC SPEECH LANGUAGE PATHOLOGY

Patient's name: ____________________________________ DOB: ____________

Parent/Guardian: ___________________________________ Phone: ____________________

Reason for referral: ☐ Speech therapy eval & treat ☐ Feeding therapy eval & treat

Medical diagnosis: ____

ICD-10 Code:

- ☐ R48.2 Apraxia
- ☐ F84.0 Autism
- ☐ F80.0 Articulation or phonological disorder
- ☐ F80.81 Childhood onset fluency disorder
- ☐ R47.1 Dysarthria
- ☐ R13.11 Dysphagia, oral phase
- ☐ F80.1 Expressive language disorder
- ☐ R63.3 Feeding difficulties
- ☐ F80.2 Mixed receptive-expressive language disorder
- ☐ F80.4 Speech and language development delay due to hearing loss
- ☐ Other: (please list code and description): _____________________________

PHYSICIAN SIGNATURE: ________________________________ DATE OF REFERRAL: ____________

PHYSICIAN NAME (PRINT): ______________________________

PHYSICIAN PRACTICE NAME:___________________________

PHONE NUMBER: __________________ FAX NUMBER: __________________

Fax Referral to: 1 (866) 225-4790