COASTAL SPEECH & SWALLOW CENTER

MEDICAL SPEECH AND LANGUAGE PATHOLOGY - SWALLOW/DYSPHAGIA SPECIALISTS

PATIENT INFORMATION

(PHYSICIAN REFERRAL)

Patient Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____

MEDICAL HISTORY

Primary Diagnosis: _____

Past Medical History: _____

Relevant Medication: _____

REASON FOR REFERRAL

___Dysphagia Evaluation
___Flexible Endoscopic Evaluation of Swallow (FEES)
___Dysphagia Therapy
___Speech-Language Evaluation
___Speech-Language Therapy Voice Evaluation
___Voice Therapy
___Cognitive-Communication Evaluation
___Cognitive Therapy

REFERRING PHYSICIAN INFORMATION

Physician's Name: _____
Physician's Signature: _____
Address: _____
Phone: _____
Email:_____

Please include recent medical history, physician notes, and imaging results (e.g., CXR, MRI, CT, VFSS, laryngoscopy, etc) when emailing this form.