Dr. Bonnie Smith
VoiceSpeechStudio.com

This document contains two forms…

… one for Otolaryngologists

… the other for Physicians

Please fill out the appropriate form and fax it to Dr. Bonnie Smith

Thank you.

Otolaryngologist Referral Form

Fax to: Dr. Bonnie Smith
VoiceSpeechStudio.com
Fax: (941) 764-6869
Phone: (941) 769-1026

Patient Name:___________________________

Patient Age:_________Birthdate:__________

Patient Diagnosis:________________________

Diagnosis code(s):________________

____

This patient is being referred for a voice evaluation (CPT 92506) and 5-8 voice therapy sessions (CPT 92507) are being ordered for this patient. These are approximately one hour each and will occur at intervals determined by Dr. Smith, the speech pathologist/voice therapist seeing this patient. These sessions are an essential part of this patient's voice restoration process and provide treatment/benefits which will not be achieved by either medical or surgical management, alone.

Physician Name (please print):__________________________

Physician Signature:____________________________________

Physician Phone Number:______________________________

Date:_______________

Physician Referral Form

Fax to: Dr. Bonnie Smith
VoiceSpeechStudio.com
Fax: (941) 764-6869
Phone: (941) 769-1026

Patient Name:___________________________

Patient Age:_________Birthdate:__________

Patient Diagnosis:________________________

Diagnosis code(s):________________

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This patient is being referred for a speech evaluation (CPT 92506) and 5-8 speech therapy sessions (CPT 92507) are being ordered for this patient. These are approximately one hour each and will occur at intervals determined by Dr. Smith, the speech pathologist seeing this patient. These sessions are an essential part of this patient's speech improvement process and provide treatment/benefits which will not be achieved by either medical or surgical management.

Physician Name (please print):__________________________

Physician Signature:___________________________________

Physician Phone Number:_______________________________

Date:______________