***a tempo* Voice Center**
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Phone: 817-262-3773 OR 817-898-8750
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Speech Therapy Referral
www.atempovoicecenter.com

Patient: _____ DOB_____

Phone: _____ Alternate phone: _____

Diagnosis: _____ Diagnosis Code: _____

Date of Onset/Injury _____ Date of Surgery: _____

Special Instructions/Precautions: _____

Choose the evaluation that best fits your patient's needs (could choose more than 1)...

____ Voice Evaluation with Videostroboscopy & Treatment

____ Chronic Cough or Vocal Cord Dysfunction Evaluation with Videostroboscopy & Treatment

____ Swallow Evaluation Fiberoptic Endoscopic Evaluation of Swallow (FEES) & Treatment

____ NMES Estim Dysphagia Therapy

Physician Signature: _____ Referral Date: _____

Physician Name (print): _____

Physician Phone: _____ Fax: _____

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