Range COMMUNITY CLINIC

SPEECH-LANGUAGE PATHOLOGY SERVICES

In Affiliation with the Department of Speech and Hearing Sciences
WSU Elson S. Floyd College of Medicine

Our clinic provides comprehensive evaluation and treatment services to individuals of all ages with speech, language, cognitive, and swallowing disorders.

We evaluate and treat individuals with a wide range of complex communication and swallowing disorders, in particular:

- Speech sound disorders
- Pediatric language disorders and delays
- Language and literacy
- Motor speech and neuromuscular disorders
- Voice and resonance disorders and paradoxical vocal fold dysfunction
- Speech, language, and cognitive problems resulting from brain injury, stroke, or neuromuscular disabilities
- Augmentative and alternative communication (AAC)
- Dysphagia (swallowing)
- Gender-affirming voice and communication

MEDICAL REFERRAL FORM

Referral Date _____

☐ Check this box, if this is a self-referral.

Patient Information _____

Patient Name _____ Date of Birth _____

Parent/Guardian/Representative Name(s) _____

Patient Address _____

City _____ State _____ Postal Code _____

Phone Primary Contact (Parent) Cell _____ Work _____

Email Primary Contact (Parent) _____

PATIENT INSURANCE INFORMATION

Primary Insurance Name _____

Insurance Group Number _____

Insurance ID _____

Primary Insurance Phone Number _____

Primary Policy Holder Name _____ Date of Birth _____

WSU Spokane • Health Sciences Building (HSB)
310 N. Riverpoint Blvd. • Spokane, WA 99202
Phone: (509) 505-7481 • Fax: (833) 471-4137
info@rangecommunityclinic.org • RangeCommunityClinic.org

in affiliation with
WASHINGTON STATE UNIVERSITY

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REFERRING PHYSICIAN INFORMATION

Referring Physician's Name _____

Practice Name _____

Address _____

City _____ State _____ Postal Code _____

Physician Phone _____ Fax _____

REQUESTED SPECIALTY CONSULTATION

TO BE FILLED OUT BY REFERRING PROVIDER

Reason/Question for Referral _____

Please check below:

☐ Clarify or establish diagnosis
☐ Advice on management
☐ Other _____

Working Diagnoses with ICD Codes

_____

Visit type: Please check below.

☐ New patient consult
☐ Evaluation
☐ Evaluation and treatment
☐ Return visit/ongoing care

Please include and annotate the following supporting documents (if applicable):

☐ Clinic notes
☐ Available vision/ audiology test results
☐ Brain Imaging and other diagnostic reports including genetic testing
☐ Previous specialty evaluations (e.g., ENT, GI, Neurology)
☐ Previous school records/ IEP or testing results
☐ Developmental assessments
☐ Previous therapy evaluation (OT/PT/Speech)
☐ MBS or FEES report

Does family require an interpreter? ☐ Yes ☐ No Which language? _____

Any known barriers to performing a successful telehealth (video) visit with the family? ☐ Yes ☐ No

Total pages sent _____

Physician Name (Printed) _____

Physician Signature _____

IN CASE OF SELF-REFERRAL

I understand this is a self-referral. I am choosing not to engage my primary care provider in requesting speech-language pathology services from Range Community Health. I understand that I will be responsible for any costs incurred.

Signature _____ Date _____

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