Vocal Concepts

SPEECH PATHOLOGY & PERFORMING VOICE CARE

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Patient: _____ Age: _____ DOB: _____

Gender: _____ Patient's primary language: _____ other: _____

Phone: _____ Alternate phone: _____ Email: _____

Diagnosis(es): _____ Dx code(s): _____

Date of onset/injury: _____ Date of surgery: _____

Guardian name: _____ Contact number: _____

Please choose appropriate evaluation(s):

_____ Voice Evaluation (92524) Laryngeal Function Studies (92520) & Treatment (92507)
_____ Upper Airway: Irritable Larynx Syndrome/Vocal Cord Dysfunction/Chronic Cough; Evaluation & Treatment
_____ SPEAK OUT! Parkinson's voice Evaluation & Treatment
_____ Clinical Swallow Evaluation (92610) & Treatment (92526)
_____ Gender affirming voice Evaluation & Treatment
_____ Singing/Performing Voice Evaluation & Treatment
_____ Group Treatment session (92508)
_____ Special instructions/precautions:_____

Please attach physician's office notes, surgical notes, and images.

Physician Signature: _____ Referral date: _____

Physician name (print) _____ Physician Specialty: _____

Physician phone: _____ Fax: _____

Form Completed by: _____ Phone/ext.: _____