INTEGRATIVE

PHYSICAL THERAPY AND SPINE TREATMENT CENTER, INC

E. Frances Seater Ed.M., M.Ed., M.S. CCC-SLP, M.Ed.

Speech-Language Pathology Referral

Patient's Name: ______________________________ Date of Birth: ______________________

Phone:______________________ Diagnosis:_______________________________________

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Eval and Treat

☐ – Speech / Dysarthria

☐ – Stuttering / Fluency

☐ – Voice

☐ – Dysphagia / Difficulty Swallowing

☐ - Hearing Loss / Aural Rehab

☐ - Cognitive - Language

SERVICES:

Speech-Language Pathology

Treatment Frequency: ____________ Treatment Duration:_____________

or Therapist Discretion:___________________________________

Physician's Signature:______________________________________ Date:______________

Print name:____

Please fax or mail this form and patient history (H&P, if applicable) to:
IPT Speech-Language Pathology - Fax #: (907) 561-6676 - Phone #: (907) 561-1711
WWW.IPTalaska.com