Columbia Speech Therapy Services

Telephone Consultation

Date / Time: _____

Client Information

Name: _____ Contact: _____

Address: _____

Phone: _____ H / C / O _____ H / C / O

DOB: _____ (m/d/yr) Age: _____ Email: _____

Current Employment, School, Other: _____

_____

Medical Hx / Concern

Referral: ___ Physician _____ Date: _____ Other: _____

Diagnosis: _____

_____

Comments: _____

_____

Speech-Language Pathology (initial impressions, patient report)

Speech: WFL _____ Voice: WFL _____ Cognition: WFL _____ Language: WFL _____

Swallowing: _____ Notes: _____

_____

Recommendations / Action

Physician referral received _____ Records for SLP evaluation received _____

Phone Consultation(s): _____

_____

Insurance (see page 2): Contacted: _____ Preauthorization: _____

Status: PENDING: financial health transportation other _____

CLOSED: financial refused Tx no response other _____

Schedule SLP evaluation _____

Name: _____ **DOB:** _____

Insurance ***(if applicable)***

Primary: _____

Group # _____ ID # _____

Phone: _____ Fax: _____

_____

Deductable: _____ Deductable to date: _____

Coinsurance/ Co-pay: _____

Limits: _____

Network Provider: _____ Out-Network Provider: _____

Contact Date: _____ Name: _____

Pre-auth: _____ Confirm # _____

Secondary: _____

Group # _____ ID # _____

Phone: _____ Fax: _____

_____

Deductable: _____ Deductable to date: _____

Coinsurance/ Co-pay: _____

Limits: _____

Network Provider: _____ Out-Network Provider: _____

Contact Date: _____ Name: _____

Pre-auth: _____ Confirm # _____

Other: _____

_____

_____