



# Provider Referral Form

CLIENT INFORMATION - PEDIATRIC

## Notice Regarding Electronic Communication and HIPAA Compliance

All referral information submitted electronically via email **must be sent from a protected, HIPAA-compliant server** to ensure the privacy and security of patient health information. Please note that **all** email communications from SaSS KC are HIPAA-compliant. If you prefer to send referrals via fax, they may be sent securely to: (913) 601-8176.

## Client Information

Child's Name	
D.O.B.	
Parent/Guardian Name	
Email	
Phone	

## Physician Information

Physician Name	
NPI #	
Office/Clinic Name	
Office/Clinic Address	
City/State	
Phone	
Fax	

<b>Referral Reason</b>			
Speech/Language Evaluation	<input type="checkbox"/>	Feeding/Swallowing Evaluation	<input type="checkbox"/>
Speech/Language Treatment	<input type="checkbox"/>	Feeding/Swallowing Treatment	<input type="checkbox"/>
Area(s) of Concern or Need			
Articulation	<input type="checkbox"/>	Language (Spoken)	<input type="checkbox"/>
Language (Written)	<input type="checkbox"/>	Fluency/Stuttering	<input type="checkbox"/>
Auditory Processing	<input type="checkbox"/>	Voice	<input type="checkbox"/>
Feeding	<input type="checkbox"/>	Swallowing	<input type="checkbox"/>
Social Language	<input type="checkbox"/>	Alternative Communication (AAC)	<input type="checkbox"/>

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Speech & Swallowing Specialists of Kansas City**

www.sasskc.com

info@sasskc.com

Phone: (816) 286-4748

Fax: (913) 601-8176