Outpatient Speech Therapy Prescription

Patient’s Name: _____________________________________________________________

Patient’s Date of Birth: _____________________________________________________

Patient / Guardian Phone: ___________________________________________________

Rehab Dx. / Dysfunction(s): _________________________________________________

Evaluate & Treat

Frequency: 1 2 3 4 5 times per week  Duration: 1 2 3 4 5 6 weeks

☐ Swallowing / Feeding
  - Functional Swallowing Assessment
  - Modified Barium Swallow Study
  - Requires Separate RX
  - Beckman Oral Motor Therapy
  - Oral Aversion
  - Compensatory Techniques
  - Head & Neck Cancer Education

☐ Vital Stim / Point Stim Therapy
  - Neuromuscular electrical stimulation to the Throat and/or Face for Dysphagia Rehabilitation and/or Facial Nerve Palsy
  - MUST BE USED WITH CAUTION IN PATIENTS WITH A HISTORY OF SEIZURE DISORDER AND/OR PACEMAKER/ICD

☐ Neurologic Rehab
  - Aphasia / Language Therapy
  - Right Hemisphere Dysfunction
  - Dysarthria
  - Cognitive-Linguistic Organization
  - Stroke / Brain Hemorrhage
  - Parkinson’s Disease
  - Amyotrophic Lateral Sclerosis (ALS)

☐ Voice Disorders
  - Assessment of Voice
  - Vocal Cord Dysfunction
  - Vocal Nodules
  - Vocal Hyperfunction
  - Passy-Muir Speaking Valve
  - Speech Training Following Laryngectomy

☐ Developmental Speech / Language
  - Receptive and Expressive Language
  - Articulation
  - Autism / Pervasive Developmental Disorder
  - Pragmatic / Social Language
  - Cognitive Skill Development
  - Fluency / Stuttering
  - Cleft Palate / Resonance Training

☐ Special Programs
  - Accent Modification / Reduction
  - Aural Rehabilitation (S.P.I.C.E. Program)
  - Lee Silverman Voice Therapy (Parkinson’s)
  - Aerophagia / GERD Program
  - Pre-Laryngectomy Counseling

Special instructions for therapist(s):

A written assessment is to be performed. The patient shall be re-certified under the physician’s care at least every 30 days for Medicare and TWCC patients.

__________________________________________________________
Physician’s Signature

Not all therapies are available at every facility. Please call your facility of choice to inquire.

Date

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