Pediatric Interactions
Helping children better communicate

Speech Language Therapy
Prescription Form
649 Barron Blvd
Grayslake, IL 60030
Fax: 847-278-0458
Phone: 847-223-7433

Date of Request: _____

Child's Name: _____ Date of Birth: _____

The above child is expected to begin receiving or has been receiving speech/language and/or feeding services and requires a current prescription to continue services. To expedite the initiation of services, this form will **SERVE AS A PRESCRIPTION** once signed and returned by the physician or a separate prescription may be sent. All prescriptions are good for one year, unless otherwise indicated. In addition, all therapist reports will be forwarded to this physician for collaboration unless family indicates otherwise. Please sign below and fax the form to **847-278-0458**. If you have any questions or need more information please contact us at (847-223-7433). Thank you for your prompt attention.

Sarah Rosten, MACIC-SLP/L

Sarah Rosten, MA,CCC-SLP/L
Speech/Language Pathologist, Director of Therapy

Service(s) and frequency requested:		CPT Codes
	_____speech/language evaluation and treatment as indicated	(92506, 92507, 92508)
	_____feeding/swallowing evaluation and treatment as indicated	(92525, 92526)
	_____speech/language therapy _____	(92507, 92508)
	_____feeding/swallowing therapy _____	(92526)

THE FOLLOWING SECTION IS TO BE COMPLETED / SIGNED BY PARENT/GUARDIAN.....

To be completed by Parent / Guardian

Physician's Name and Practice: _____

Address: _____

Phone: _____ fax: _____

The above health care provider or medical facility, has my authorization to obtain from or provide to Pediatric Interactions, information concerning the above stated child's care, condition and treatment for the purposes of treatment, payment or healthcare operations. I have received Pediatric Interactions' Notice of Privacy Practices.

Parent/Guardian Signature: _____ Date: _____

TO BE FAXED BY PEDIATRIC INTERACTIONS ONCE ABOVE SECTION HAS BEEN COMPLETED / THE FOLLOWING IS TO BE COMPLETED BY THE ABOVE PHYSICIAN AND RETURNED TO PEDIATRIC INTERACTIONS.....

To be completed by Physician

Primary Diagnosis/ICD-10 Code: _____ Secondary Diagnosis/ICD-10 Code: _____

Precautions if any: _____

Frequency/duration: _____

Date: _____ Physician Signature: _____ License#: _____

Code Reference from ICD10coding.com

F84.0 Autistic disorder	F84.8 Pervasive developmental disorder	F84.5 Asperger's syndrome
F80.81 Stammering & stuttering	G93.40 Encephalopathy	H66.90 Otitis chronic media
H91.90 Hearing impaired	H90.41 Hearing loss-right ear	M26.63 Articulation disorder
Q35.9 Cleft palate	H90.42 Hearing loss-left ear	R63.3 Feeding problems
Q90.9 Down syndrome	P07.00 Relating to extreme immaturity of infant	
P24.9 Aspiration newborn & fetal	P07.10 Premature birth	R56.00 Seizure disorder
R62.51 Failure to thrive, gain weight	R63.1 Oral-motor dysfunction	R62.0 Delayed milestones, late talker
R49.8 Hypernasality	R47.89 Other speech disturbance	R13.10 Dysphagia
R48.2 Apraxia	R48.9 Symbolic Dysfunction	F80.2 Mixed receptive/expressive disorder