Stony Brook Medicine

PATIENT REFERRAL

To: Outpatient Speech Pathology
Stony Brook University Hospital
Tel: 631-444-4191
Fax: 631-444-4582

Patient Name: _____
DOB: _____
Pt. phone#s: _____
Dx/ICD9: _____

Patient PMHx:_____
_____

Rx/ Plan of Care:

☐ **Evaluation:** ❑ Swallow ❑ Videoflouroscopic Swallowing Study (VFSS)

❑ Pre-treatment Head /Neck Cancer ❑ Fiberoptic Endoscopic Evaluation of Swallowing (FEES)

❑ Voice ❑ Speech ❑ Language/Cognition ❑ AAC/SGD- Augmentative/Alternative Communication/Speech Generating Device

❑ Pre-Op Laryngectomee ❑ Insufflation Test/TEP Eval ❑ TEP Voice Prosthesis Fitting/Training

☐ **Treatment:** _____ X/Week

❑ **Swallowing:**
Posture/Positioning
Oral Motor Exercises
Airway Closure Exercises
Pharyngeal Pressure Exercises
Neuro Muscular Electric Stimulation

❑ **Voice:**
Vocal Hygiene
Diaphragmatic Breathing
Vocal resonance exercises
Voice Restoration Services

❑ **Speech/Language**:
Articulation
Receptive/Expressive
Fluency
Memory/Attention/Cognition
Word Retrieval/Compensatory Strategies

❑ _____

❑ **CommunicationDevice:**
Attain access, program and train use

Goals:

❑ Safe oral p.o. at least restrictive diet level
❑ Improve swallow function
❑ Improve speech intelligibility
❑ Improve communicative competence
❑ Improve ventilatory support for voice, vocal production and reduce phonatory tension

Verbal order obtained from physician _____ SLP Signature / Date
The above treatment plan was reviewed with patient and/or family and in agreement with plan.

Physician: Please sign and return to the Speech and Hearing Department ASAP to avoid any delays in treating your patient.

Physician's Name: _____ **Phone #:** _____

Physician's Signature: _____ **Date:** _____