COLUMBUS SPEECH & HEARING CENTER
We Improve Communication for Life

Referral for Speech and/or Audiology Services

This patient is being referred for (please check one or both) ☐ **Speech Services** ☐ **Hearing Services**

Date of Referral: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian's Name (If applicable): _____

Diagnosis: _____

Brief description of issue/other relevant information: _____

_____

_____

Insurance Information:

Primary: _____ Secondary: _____

*We accept most insurance. We also accept self pay patients and will work with those insurance companies that allow out-of-network coverage. **We are only able to accept Medicare for audiology services.*

Referring Physician: _____

Practice Name: _____

Office Contact Name: _____ Phone: _____

This referral may be faxed directly to our scheduling staff at 614.263.5365 and the patient will be contacted as soon as possible.

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www.columbusspeech.org

United Way
United Way of Central Ohio