UPWORDS
Speech Therapy Services

Speech-Language Evaluation and Treatment Referral/Prescription

Patient Name: _____

DOB: _____

Date: _____

Phone: _____

Diagnosis: _____

Service Requested

☐ Evaluation and Treatment of Speech/Language

I hereby certify the medical necessity of the service listed above.

Physician Name: _____

Physician Signature: _____

Physician Phone: _____

Practice Name: _____

Physician NPI: _____

FAX ALL THERAPY PRESCRIPTIONS TO: (844) 564-1402

www.upwordsspeech.com ~ 614-401-4644 ~ info@upwordsspeech.com