



REFERRAL FOR OUTPATIENT **COCHLEAR IMPLANT SLP PROGRAM**

FAX to the RUSK BUSINESS OFFICE (212) 263-8257

Date: _____

Patient Name: _____

Patient Date of Birth: _____ Patient Social Security Number: _____

Parent/Guardian Name (if appropriate): _____

Patient / Guardian Telephone Number: Contact 1: (____)____ - _____

Contact 2: (____)____ - _____

PLEASE NOTE: If patient cannot be contacted directly, with whom should we speak? _____

Patient Address: _____

Primary Language: _____

Primary Insurance: _____ Policy Number: _____ Insured Name: _____

Secondary Insurance: _____ Policy Number: _____ Insured Name: _____

Medical Diagnosis: _____

ICD 9: _____

_____ Sensory neural hearing loss

_____ Other _____

Onset Date: _____

_____ Speech-language pathology evaluation

_____ Communication rehabilitation (pre-lingual)

_____ Communication rehabilitation (post-lingual)

_____ Other _____

Prescription for: (please select)

_____ Evaluation only

_____ Evaluation and Treatment:

_____ (times/week)

_____ (number of months)