NYU Medical Center **RUSK INSTITUTE** of Rehabilitation Medicine

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-langue 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)

Physician's Name (Please Print): _____
License Number: _____ UPIN: _____
Office Telephone: _____Office Fax: _____
Physician's Signature: _____