P.H.L. Joseph Belanger, DO, FAOCO
Matthew Bowen, MD, FAAOA
Craig R. Hoekzema, MD
Paul E. Lomeo, DO, FAOCO
George McLaughlin, PA-C

WEST SHORE
E.N.T. & ALLERGY

Susan K. Barnard, MA, CCC-A
Valerie Brickner, AuD, CCC-A
Julie Cole, MA, CCC-SLP
Kailey Riker, MA, CCC-SLP
Alicia VanderZanden, AuD, CCC-A

SPEECH THERAPY REFERRAL FORM

Name: ____

Address: ____

City: ________________________________ State: _______ Zip: _______________

Phone: (   ) __________________________ Alternate Phone: (   ) _________________

Date of Birth: _____________________

Insurance: ____

Diagnosis: ____

- **Please include clinical notes, recent radiology and pathology reports and any other information to help us in the continuation of care for your patient.**

Referred for:

Speech Therapy Services
- ☐ Speech Evaluation and Treatment
- ☐ Swallow Evaluation and Treatment

Instrumental Diagnostic Testing
- ☐ Videostroboscopy
- ☐ Fiberoptic endoscopic evaluation of swallowing (FEES)

- -

Referred by: ____

Contact Person: ____

Date of Request: _________________________

Managing Physician Information:

Name: ____

Address: ____

City: ________________________________ State: _______ Zip: _______________

Phone Number: (   ) _________________________________

Fax Number: (   ) ____

- **All appointments are at our Norton Shores location.**
- **Please allow 24 hours for the scheduling of referral appointments.**
- **If you feel this is an urgent matter, please call our office directly at (231) 777-2625.**
- **Please give the patient a copy of our strobe intake questionnaire. Thank you.**

Appointment scheduled for _______________________________ at ___________________