



**We are Speech Inspirations and we want to help you and your clients with their Speech and Occupational Therapy needs!**

We would love to set up a meeting to further discuss your practice goals and how we can both benefit from a mutual referral relationship. Contact us below!

Insurances we accept	Accepting ages 2yrs+ for:
<ul style="list-style-type: none"> <li>● Aetna</li> <li>● Amerihealth</li> <li>● BCBS</li> <li>● Carolina Complete</li> <li>● Cigna</li> <li>● Healthy Blue</li> <li>● NC Medicaid</li> <li>● SC Medicaid</li> <li>● Medicare</li> <li>● Tricare</li> <li>● United HealthCare</li> <li>● Community/Commercial Plans</li> <li>● Wellcare</li> </ul>	<ul style="list-style-type: none"> <li>● Post-stroke difficulties               <ul style="list-style-type: none"> <li>○ Aphasia/Speech</li> <li>○ Swallowing</li> </ul> </li> <li>● Swallowing disorder due to COPD</li> <li>● Parkinson's disease</li> <li>● Feeding</li> <li>● Dyslexia</li> <li>● Phonological awareness</li> <li>● Reading support</li> <li>● Speech-language delay</li> <li>● &amp; MORE!</li> </ul>

**Office Information**  
 4909 Waters Edge Drive  
 Raleigh, NC 27606  
[www.SpeechInspirations.com](http://www.SpeechInspirations.com)

**Contact us!**  
**Phone** (919) 285-1647  
**Fax** (919) 576-1366  
**Email** [info@speechinspirations.com](mailto:info@speechinspirations.com)

We've included a blank referral form for your convenience.  
 We offer **in-home** care as well as **teletherapy** options.





Speech Inspirations PLLC  
**Phone** (919) 285-1647 - **Fax** (919) 576-1366  
**Email** info@speechinspirations.com

**Referral Form for Speech Therapy OR Occupational Therapy Services**

Please fax this order and most recent visit notes from your practice to **919-576-1366**.

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Relevant Medical Diagnoses**

**Date of Onset**

\_\_\_\_\_  
\_\_\_\_\_

**Reason for Referral** (Please check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Language/Cognition               | <input type="checkbox"/> Augmentative Communication     |
| <input type="checkbox"/> Stroke Rehabilitation            | <input type="checkbox"/> Swallowing/Dysphagia Therapy   |
| <input type="checkbox"/> Sound production/intelligibility | <input type="checkbox"/> Speech/Language Delay/Disorder |
| <input type="checkbox"/> Voice Therapy                    | <input type="checkbox"/> Dyslexia/Reading Concerns      |
| <input type="checkbox"/> Sensory or fine motor concerns   | <input type="checkbox"/> Other: _____                   |

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_

As of November 1st, 2016 physicians must include individual NPI and must be an enrolled Medicaid provider.  
Please sign, date, and include physician's name and NPI number above.