2 Pillsbury Street, Suite 404
Concord, NH 03301
Phone: (603) 228-STAR (7827)
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Speech Therapy Doctor's Order

Child's Name: ________________________ Parent's Name: ____________________
Date of Birth: ________________________ Phone Number: ____________________

Services Requested:

☐ Speech Therapy Evaluation
☐ Speech Therapy Treatment

Diagnosis (ICD 10):

☐ F84.0- Autistic Disorder
☐ F84.5- Asperger's Syndrome
☐ F84.8- Other Pervasive Developmental Disorder
☐ F91.0- Conduct disorder, confined to family
☐ F91.1- Conduct disorder, childhood onset type
☐ F91.2- Conduct disorder, adolescent onset type
☐ F91.3- Oppositional defiant disorder
☐ F94.1- Reactive Attachment Disorder

☐ F41.1- Generalized Anxiety Disorder
☐ F90.0- ADHD, inattentive type
☐ F90.1- ADHD, hyperactive type
☐ F90.2- ADHD, combined type
☐ Q90.9- Downs Syndrome
☐ Q99.2- Fragile X Chromosome
☐ F94.0- Selective mutism
☐ F94.8- Other childhood disorder of social function

☐ F80.0- Phonological disorder
☐ F80.2- Mixed receptive-expressive language dis.
☐ F98.29- Other feeding disorders of infancy & early childhood
☐ R47.02- Dysphasia
☐ R47.81- Slurred speech
☐ R49.0- Dysphonia
☐ R63.3- Feeding difficulties
☐ R62.59- Other lack of expected normal physiological development in childhood
☐ Other: ___________________________________

☐ F80.1-Expressive language disorder
☐ F80.81- Childhood onset fluency disorder
☐ F80.89- Other dev disorders of speech & language
☐ R47.1- Dysarthria & anarthria
☐ R48.2- Apraxia
☐ R62.0- delayed milestones in childhood
☐ R63.8- other sx & signs concerning food & fluid intake

I do hereby determine the services listed above to be medically necessary

Physician's Signature: __________________________________ Date: _______________________

Physician's Name Print: ________________________________ NPI Number: ________________

Address: ____ Phone Number: _______________