Speech/Language Referral

Student Information

Name: ____ D.O.B. __________

Address: ____

School District: ____

Diagnosis

____

____

Recommended Frequency and Duration of Services

( ) I do not recommend speech/language therapy.

( ) I recommend speech/language therapy for the above named student at the following frequency and duration____.

Referring Provider

Physician or LPHA* (Printed Name): ____

Signature: ____________________________________ Date: __________________________

*Licensed Practitioner of the Healing Arts (LPHA) include but are not limited to, physicians assistants, advanced practice nurses, clinical psychologists, speech-language pathologists or individuals with a Professional Educator License (PEL) endorsed in School Psychology or Speech Language Pathology.

12/15/16-go