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.

Referring Provider

Physician or LPHA* (Printed Name): _____

NPI Number of Referring Provider: _____

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.