

SLI - Physician Voice Referral Form

Date: _____

TO: _____
Parent/Guardian

RE: _____
Student

Your child has been referred for a speech evaluation because of concerns regarding his/her voice. Before considering voice intervention, medical clearance by a physician is necessary.

Please ask a physician (preferably an otorhinolaryngologist – ENT) to complete the following information. Please return this form to:

_____ at _____
(Speech Language Pathologist-please print) (School)

Speech Language Pathologist Phone Fax

To the Physician:

Please complete the information below regarding your examination of the above named child.

Diagnosis:

Medical Treatment:

Recommendation(s):

This student has medical clearance to receive voice therapy provided by a speech language pathologist. Yes _____ No _____

Signature of Physician: _____ **Date:** _____

Address: _____

Phone: _____