SAMPLE REFERRAL FORM FOR A STUDENT WITH MEDICAID RECEIVING SPEECH AND LANGUAGE SERVICES IN THE SCHOOL SETTING

STUDENT INFORMATION:

Name: ___________________________ Birthdate: ____________

Address: _________________________ City/State/Zip: ____________

RECOMMENDED TREATMENT:

[ ] Speech/Language Therapy for the _________ - _________ school year

Comments: ________________________________________________

REFERRING PROVIDER:

Physician or LPHA* (Printed Name): __________________________________________

Signature: ___________________________________________ Date: ____________

Examples of LPHA’s include physician assistants, advanced practice nurses, clinical psychologists, and IDFPR licensed speech-language pathologists. Also included as LPHA’s are individuals with an ISBE Professional Education License (PEL) endorsed in School Psychology or Speech-Language Pathology.