Revised 2-11-11

SCHOOL DISTRICT NAME
SAMPLE REFERRAL FOR
SPEECH THERAPY EVALUATION/TREATMENT

Items in italics are not required by the LEA Manual, but may be of use to districts.

Student:		DOB:	(M/D/YYYY)
School:		*Grade:*	
IEP Review Date:			
Evaluating/Treating Speech Therapy Professional (if identified):			
Medicaid Number:			

IMPORTANT: This section must be completed by the referring Physician or LPHA.

The student is being referred for the following:

☐	_____
☐	_____

The reason for this referral is:

☐

☐ Documented or
☐ Suspected

- ☐ Development Language Disorder
- ☐ Acquired Language Disorder
- ☐ Articulation/Phonological Disorder
- ☐ Fluency Disorder
- ☐ Voice Disorder
- ☐ Resonance Disorder
- ☐ Dysphagia
- ☐ Other

Additional Comments:	
Physician /LPHA[1] Signature:	
Title:	
Date of Referral (M/D/YYYY):	

Note: The referral must be updated no later than the annual renewal of the IEP/IFSP. It must be obtained from a physician or Licensed Practitioner of the Healing Arts acting within the scope of practice under state law. The referring entity may not be the same person who conducts the evaluation or provides treatment. The referral must be clearly documented in the clinical record with the name, date, and title of the provider. This can be found in section two of the LEA Medicaid Policy Manual.

[1] The Medicaid LEA Provider Manual defines Licensed Practitioner of the Healing Arts in section two of the manual.