Comprehensive Language and Speech Evaluation Referral

PATIENT INFORMATION

Name: | DOB: | Age:

Gender: ☐ Male ☐ Female ☐ Other ________ | School District:

Home Language: | Student Language:

Does the patient have an IEP/IFSP?: ☐ IEP ☐ IFSP ☐ No

Parent/Guardian Name:

Street Address:

City: | County: | Zip Code:

Phone Number: | Email Address:

Preferred Contact Method: ☐ Phone Call ☐ Text ☐ Email

REFERRAL INFORMATION

Referred By: | Relationship to patient:

EI Provider/Teacher of the Deaf: | Email:

Audiologist: | Email:

Previous/Current Services: ☐ Early Intervention ☐ Private Therapy ☐ Other ____________

Information included with referral: ☐ IEP/IFSP ☐ Audiogram ☐ Evaluation/Report

Reason for referral:

Special considerations:

SUBMISSION INSTRUCTIONS

Referral sent by: ☐ Email (ellyn.mccall@hearindiana.org) ☐ Fax (888-887-0932)

Please make sure that all sections of this form are complete so that the referral can be processed.

Once the referral is received intake paperwork wil be sent to the family. When intake paperwork is completed, the patient will be schedule for a comprehensive language and speech evaluation.

Please email ellyn.mccall@hearindiana.org with any questions. Thank you!

For office use only: Date referral received ________________