

School District School-Based
Speech Therapy Referral for Evaluation/Treatment Form
For the 20__ to 20__ School Year

Student Name		DOB:	
Medicaid #:		Student ID #:	
Date of IEP Review:		School Name:	

The student is being referred for the following: check all that apply

	Speech Language Evaluation (check this box for Medicaid evaluation purposes)
	Initial assessment to determine eligibility
	Update present levels of performance, modify treatment plan indicated

The following speech-language disorders are:

- | | |
|--|---|
| <input type="checkbox"/> Documented or
<input type="checkbox"/> Suspected | <input type="checkbox"/> Student failed speech-language screening on: _____ |
|--|---|

Medical Diagnoses (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Apraxia of Speech – R48.2
<input type="checkbox"/> Auditory Processing Disorder – H93.25
<input type="checkbox"/> _____
<input type="checkbox"/> Dysphagia, unspecified – R13.10
<input type="checkbox"/> Dysphagia, oral phase – R13.11
<input type="checkbox"/> Dysphagia, oropharyngeal phase - R13.12
<input type="checkbox"/> Dysphagia, pharyngeal phase – R13.13
<input type="checkbox"/> Expressive language disorder-F80.1
<input type="checkbox"/> Mixed receptive-expressive language disorder –F80.2
<input type="checkbox"/> Speech and language development delay due to hearing loss-F80.4
<input type="checkbox"/> Childhood-onset fluency disorder-F80.81
<input type="checkbox"/> Feeding Difficulties – R63.30 | <input type="checkbox"/> Social pragmatic communication disorder-F80.82
<input type="checkbox"/> Other developmental disorders of speech and language-F80.89
<input type="checkbox"/> Developmental disorder of speech and language, unspecified-F80.9
<input type="checkbox"/> Other speech disturbances. R47.8
<input type="checkbox"/> Slurred speech-R47.81
<input type="checkbox"/> Other speech disturbances-R47.89
<input type="checkbox"/> Speech Disorder (nonverbal) R47.9
<input type="checkbox"/> Speech Delay – F80.4
<input type="checkbox"/> Global Developmental Delays – F88
<input type="checkbox"/> Unspecified cleft palate with bilateral cleft lip - Q37.8
<input type="checkbox"/> Other reason _

_____ |
|---|--|

Therapeutic Recommendations (check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> AAC/Speech-Generating Devices
<input type="checkbox"/> Cognitive-Communication Treatment
<input type="checkbox"/> Fluency Treatment
<input type="checkbox"/> Language Treatment | <input type="checkbox"/> Myofunctional Treatment
<input type="checkbox"/> Neurological Motor-Speech Treatment
<input type="checkbox"/> Social Communication Treatment | <input type="checkbox"/> Speech Sound Disorders Treatment
<input type="checkbox"/> Swallowing Treatment
<input type="checkbox"/> Voice and/or Resonance Treatment
<input type="checkbox"/> Feeding Therapy |
|---|---|---|

Additional Comments:

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Referring Provider Print Name: _____ Signature: _____

Practice Name: _____ Credentials: _____ Date: _____

*** Note:** The referral documentation must occur prior to the provision of the Medicaid evaluation and Rehabilitative Therapy Service. The referral must meet the following requirements: be updated before the annual renewal of re-evaluation and the IEP, be obtained from an LPHA other than the direct provider of services (e.g., the referring LPHA cannot supervise the service or cosign the documentation), be clearly documented in the clinical records with the name, date and title of the provider and explain the reason for the referral.