SLI - Physician Voice Referral Form

Date: ______________________

TO: ____
Parent/Guardian

RE: ____ DOB: ____________
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 or ENT) to complete the following information. Please return this form as soon as possible to:

_____________________________________ at ________________________________
Speech-Language Pathologist - please print School

_____________________________________ ________________ ________________
Speech-Language Pathologist Phone Fax

To Be Completed by 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: ____