SPEECH LEARNING CENTER

Speech/Language Referral Form

Child's Name: _____

Birthdate (mm/dd/yyyy): _____

School/Grade: _____

Parent/Guardian Name: _____

Address:

Phone Number: _____

Email: _____

Health Insurance Name: _____
If Medicaid, please indicate *Illinois Health Connect* _____ or *HMO*_____

Please check the appropriate area of concern and provide a description of the specific area of speech and language concern:

Articulation/Sound Errors ( ):

_____

Receptive/Expressive Language ( ):

_____

Fluency ( ):

_____

Other ( ):

_____

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