University of Missouri

Communication Science and Disorders
School of Health Professions

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MU SPEECH AND HEARING CLINIC
REFERRAL/REQUEST FOR SERVICE

DATE: ___________ ☐ **DX** (Speech-Language Evaluation) ☐ **TX** (Speech-Language Therapy)

CLIENT'S NAME: ______________________________ BIRTHDATE: ______________

ADDRESS: ____

PARENTS: ____

PHONE: (Home)_____________ (Work)__________________ (Cell) ________________

(Indicate preferred phone #) (may we leave a message) ☐ yes ☐ no)

EMAIL: ____

SCHOOL & GRADE (OR EMPLOYER): _______________________________________

Referred by: ____
(Referral phone # should be taken if appropriate)

PROBLEM: ____

____

PREVIOUS/CURRENT SPEECH-LANGUAGE HEARING SERVICES: ______________

____

DOES THE CLIENT HAVE A BCFR CASEWORKER? YES NO
CASEWORKER'S NAME: ___________________________PHONE NUMBER: ________

☐ The following has been explained to the responsible party, including the option to apply for financial assistance:
"This is a University training program. Our services are provided by graduate students under the direct supervision of licensed, certified speech-language pathologist. I also want to make sure that you are aware that there are charges for our clinical services. Because we are a training program, our fees are typically only one half to one third of the customary fees in hospitals and private clinics. If you do not have insurance and these fees represent an obstacle to your receiving speech-language services, you may qualify for financial assistance. We will send our fee schedule to you and you may request a financial assistance form."

Financial assistance form requested? ☐ Yes ☐ No

Initial Contact (initials): ____ Date: ________Follow-up Contact (initials): ____ Date: ________

NOTES: ____