**Delaware County Funded Client Referral Form**



**Lynn Gay, M.A. CCC-SLP Upper Arlington Speech Therapy Services**

614.204.5066

Please complete this form for speech therapy referral(s) and return as a Word Document to Lynn@uaspeech.com

**\*Type all information on to this Word Document (Do Not print out and write on this form)**

**Date of Referral: -**

**DCBDD Funding Source Information:**

Case Manager’s Name:

Phone Number:

Email Address:

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Name:

Age:

DOB:

Speech Diagnosis/Issue:

Is the client verbal? (Yes/No):

Does the client have an AAC device (Communication Device)? (Yes/No):

**Contact Information:**

Parent/Caregiver Name(s):

Phone Number:

Email Address:

Home Address:

**Day Program/Care Information:** If Applicable:

Name of Program:

Address:

Phone Number:

Contact Person:

Email Address:

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**Additional Information:**

Does the client have a current IEP or Speech Evaluation with current/appropriate Speech Goals? (Yes/No)

-If so, please contact the school and ask them to send you the electronic IEP, then when you received it, forward it to me at Lynn@uaspeech.com

Please list any other helpful information: