Babel Therapy
Changing Lives Through Communication
3107 Willowbend Rd. Montgomery, TX 77356
PH: 936.703.5064 FX: 936.703.5064 www.BabelTherapy.com

# SPEECH-LANGUAGE SCREENING & CONSULTATION REQUEST

Date of Request:_____ Date Received:_____

Name:_____ DOB:_____

HCS Provider Name: _____ Coordinator:_____

Day Habilitation Program:_____

Address:_____

Parent/Guardian:_____ Phone:_____

Home Address:_____

This form constitutes a request for screening, with parent/guardian permission, to determine whether areas of concern can be addressed within the consumer's regular dayhab environment or if a speech and language evaluation referral is needed. This screening will include a review of the consumer's communicative abilities and can address language comprehension and use, articulation, fluency, voice or alternate forms of communication such as high tech speech output devices or low tech communication boards. Results and recommendations will be reviewed with caregiver and coordinator to determine plan of action.

**Reason for Screening Request** :( check all areas of concern)

- ☐ Misarticulating sounds/Speech
- ☐ Grammar difficulties
- ☐ Language comprehension
- ☐ Expressive language
- ☐ Listening skills
- ☐ Difficulty with fluency
- ☐ Voice differences (such as hoarseness, hypernasality, pitch, rate, volume)
- ☐ Non Verbal Communicator
- ☐ Other_____

**Comments (Please provided specific examples to support request)**

_____

_____

Referred By:
_____

***Obtain parent/guardian consent and forward to Babel Therapy**

☐ I **do** give consent to conduct the screening

☐ I **do not** give consent to conduct screening

_____ _____

**Parent/Guardian Signature** **Date**