



Amarillo Independent School District

TEXAS SCHOOL HEALTH AND RELATED SERVICES Medicaid Reimbursement Program SPEECH/LANGUAGE THERAPY REFERRAL AUTHORIZATION

STUDENT INFORMATION

DATE: _____

Name: _____

DOB: _____

Student ID#: _____

MEDICAID #: _____

Campus: _____

Parent(s): _____

Address: _____

Telephone: _____

- I have reviewed** the speech, hearing and language clinical history, the test results, recommendations, and/or Individual Education Plans (IEP) on this student.
- I recommend** that this student receive therapy, from a certified Speech Therapist or Speech Pathologist, as prescribed in the treatment/service schedule of the Individualized Education plan (IEP). This recommendation is effective for the duration of the student's current IEP.
- I do not recommend** this student for Speech/Language Therapy.

Signature of Referring Speech Pathologist

Date

Printed Name

License/Certification Number