Ionia County Intermediate School District

Speech Therapy Referral

Student: DOB:
District:
Dear Physician:

This student qualifies as having a speech and language impairment in accordance with the Michigan Revised Administrative Rules for Special Education (June 6, 2002). Through formal assessment the communication disorder that adversely affects educational performance has been determined to be:

☐ Language ☐ Articulation ☐ Fluency ☐ Voice

In order for school districts to bill Medicaid for speech therapy services the Michigan Department of Community Health guidelines state that a referral must be ordered in writing by a physician. A referral means, "contact by a physician with the speech pathologist or audiologist providing the services or with an enrolled School Based Services provider for special education and related services."

If you agree with this referral, please sign and return to the person listed below. Feel free to call me at ______________________________ if you have any questions.

Sincerely,

____
Speech/Language Pathologist

I agree with the referral for speech, language and hearing services for this student, inclusive of assistive technology device services as necessary. This is effective September 1, .

______________________________________ ______________________
Physician Signature Date

Please return to:
Jim Lóser
Ionia County Intermediate School District
2191 Harwood Rd
Ionia, MI 48846