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Pediatric Screening Form

Child's Name: _____Date of Birth: _____

Parent's Name (s): _____Phone:_____

Email address: _____

Child's school: _____Grade:_____

Referred by?

First Name: _____ Last Name: _____

REASON FOR REFERRAL:

What are your main concerns about your child's speech/myofunctional skills?

When did you first become concerned with your child's speech/myofunctional skills?

Has your child ever received a speech/language evaluation?

Yes_____No_____Date: _____

Has your child received speech/language therapy previously?

Yes____ No____ If yes, when and for how long? _____

Has your child ever receive any other medical/ developmental evaluations? Yes/No

If yes, what evaluations? _____

What were the results? _____

Please return this form to dinaezslp@gmail.com