



## REFERRAL SLIP

Please fax this form to the office: 858-746-4113 or email it to: [Info@SanDiegoCenterForSpeechTherapy.com](mailto:Info@SanDiegoCenterForSpeechTherapy.com)

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Email: \_\_\_\_\_ Referred by (name): \_\_\_\_\_

Referral Phone: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

### OROFACIAL MYOFUNCTIONAL THERAPY

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Thumb/finger/pacifier sucking habit | <input type="checkbox"/> Drooling                    | <input type="checkbox"/> Speech concerns        | <input type="checkbox"/> Mouth/Face/Jaw muscle pain |
| <input type="checkbox"/> Mouth breathing/lips open at rest   | <input type="checkbox"/> Tongue thrust               | <input type="checkbox"/> Sleep breathing Issues |   |
| <input type="checkbox"/> Tongue position at rest             | <input type="checkbox"/> Chewing/eating difficulties | <input type="checkbox"/> Clenching/grinding     |   |

Comments: \_\_\_\_\_

### SPEECH & LANGUAGE THERAPY

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Delayed talking, not speaking yet, or limited speech                                 | <input type="checkbox"/> Difficult to understand                                       | <input type="checkbox"/> Feeding, swallowing, drooling, oral-motor challenges  |
| <input type="checkbox"/> Speech articulation challenges / speech sound errors                                 | <input type="checkbox"/> Stuttering  | <input type="checkbox"/> Voice concerns (e.g., hoarseness, pitch issues, etc.) |
| <input type="checkbox"/> Language processing/comprehension concerns   | <input type="checkbox"/> Shyness, not speaking in various situations, selective mutism | <input type="checkbox"/> Social skills/pragmatics concerns                     |
| <input type="checkbox"/> Expressive language challenges, grammar/syntax issues, difficulty expressing oneself |  |  |

Comments: \_\_\_\_\_

### OCCUPATIONAL THERAPY

- |   |  |
|---|--|
| <input type="checkbox"/> Sensory integration/regulation concerns  | <input type="checkbox"/> Motor planning, strength, endurance, balance, & coordination challenges |
| <input type="checkbox"/> Self-help & activities of daily living concerns  | <input type="checkbox"/> Feeding, picky eating, & food avoidance issues                          |
| <input type="checkbox"/> Attention & organizational skill difficulties  | <input type="checkbox"/> Visual motor or visual perceptual concerns                              |
| <input type="checkbox"/> Fine motor challenges (e.g., handwriting, scissor skills, dressing, utensil use, etc.) |  |

Comments: \_\_\_\_\_



### PHYSICAL THERAPY (WATER AND SPORTS PHYSICAL THERAPY)

Physician diagnosis/condition: \_\_\_\_\_

### EDUCATION/ACADEMIC SERVICES

- Learning difficulties     Reading challenges, dyslexia

Concerns in specific academic areas/comments: \_\_\_\_\_



San Diego Center for

**Speech Therapy**

Myofunctional • Physical • Occupational

## ADDITIONAL COMMENTS

Large empty white box for additional comments.



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