UNIVERSITY OF SOUTH DAKOTA

DEPARTMENT OF COMMUNICATION SCIENCES & DISORDERS
USD SCOTTISH RITE CHILDREN'S CLINIC FOR SPEECH AND LANGUAGE DISORDERS

Request for Services

Date: _____ Person completing this form: _____

Services requested:

_____ Speech & Language Evaluation _____ Dyslexia Evaluation _____ Re-eval for Dyslexia

_____ Speech & Language Therapy _____ Orofacial Myofunctional Evaluation (ex. tongue thrust)

Child's First Name: _____ Last Name: _____ Birth Date: _____/_____/_____

School: _____ Grade: _____ M ____ F ____

Parent/Guardian: _____ E-mail: _____

Address: _____ Phone: _____

City: _____ Zip: _____ Cell: _____

Primary care physician: _____ Referring physician: _____

Please describe your specific concerns regarding your child: _____

_____

_____

_____

_____

Describe your child's background, any diagnoses or significant medical problems (ex. Autism, Hearing Loss, etc.) as well as any help he/she has received or is receiving: _____

_____

_____

Please include with this form previous standardized testing (psychological/IQ, academic achievement, speech and language, etc.) done by your child's school or other agency. Also, if applicable, include a copy of your child's most recent IEP or 504 plan.

Send this Request for Services form in with any additional information via fax or mail to USD Scottish Rite Children's Clinic (information below).

What to expect after this "Request for Services" has been completed.

- ➔ You will be contacted by email (or phone) to offer an appointment (this may take up to 6 months).
- ➔ Your request will be placed on a waiting list, in the order received, for the next opening.
- ➔ Evaluation appointments are scheduled to correlate with USD's academic calendar (Fall, Spring & Summer Semesters) and are typically scheduled in blocks. We greatly appreciate your patience and understanding through this process.
- ➔ Once your appointment has been confirmed, you will be sent our comprehensive paperwork packet. Please fill out and bring with you to your appointment.

Insurance information: ___ Medicaid ___ Blue Cross ___ Dakota Care ___ Sanford ___ Avera

Other: _____

Billing: Our office will contact you once we have received this form to discuss insurance and/or payment options. In the case of financial hardship, a sliding fee schedule is available.

United Way

Address: 520 S. 1st Avenue, Sioux Falls, SD 57104-6902
Phone (Sioux Falls Clinic): 605-336-7561 Phone (Vermillion Clinic): 605-677-5474
Fax: 605-330-9820 Website: www.usd.edu

RiteCare Speech Language and Literacy
Helping Children Communicate
USD Scottish Rite Children's Clinic for Speech & Language Disorders