ALIGNED
INTERVENTION SERVICES INC.

Speech-Language Pathology Client Information & Referral Form

Name:	Date of Birth:	
Parent/Guardian:	Email:	
	Contact Number:	

Please Check Area(s) of Need:

- ☐ Mouth Breathing
- ☐ Snoring, teeth grinding, TMJD
- ☐ Low Tongue Posture
- ☐ Feeding
- ☐ Thumb Sucking
- ☐ Difficulty producing speech sounds clearly (e.g., 's', 'r', 'l')
- ☐ Stuttering
- ☐ Reading Difficulties

☐ Parent/Patient is aware of this referral and has provided consent for information to be shared

Fee for Service: $180/hr, $90/half hour

Located in the Bonnyville Business Center (4816-51 Avenue, Bonnyville, AB)

☐ Parent/Patient has consented to dental office sharing the Dentists' findings, recommendations, and treatment plan. If so, please attach information to this referral from.

Please fax form to 1-587-701-5033 to submit referral to Speech-Language Pathologist.

Referring Clinic Contact Information:

_____
Dentist Signature

alignedinterventionservices@gmail.com Phone: 780-812-1176 Fax: 587-701-5033