SAN FRANCISCO STATE UNIVERSITY
NICHOLAS CERTO SPEECH, LANGUAGE AND HEARING CLINIC

F-25: RECOMMENDATION FOR CLIENT—SLHS 880 and/or SLHS 884

Client Name: _____ File Number: _____

Service(s) Provided: _____ Clinician: _____

Supervisor: _____ Date of Recommendation: _____

RECOMMENDATION: (Please check appropriate spaces)

☐ The client is recommended for _____ (type(s) of service)

for _____ (semester) 20_____.

☐ No additional services are recommended at this time. The client/family is recommended to contact us for a re-evaluation if they observe or have concerns about the following:

_____

☐ Services are recommended but the client/family has declined for the following reason(s):

_____

PLEASE PROVIDE CONTACT INFORMATION FOR US TO SCHEDULE SERVICES

☐ The client's address and telephone number are correct as listed in the folder.

☐ The client's address and telephone number have changed. The corrected information is:

Email: _____

Phone: _____

Address: _____

_____

ADDITIONAL SCHEDULING OR OTHER INFORMATION:

_____

Client/Family Signature _____

_____ _____

Supervisor's Signature Clinician's Signature