MISS B'S BUTTERFLIES
ABA, PT, OT, and ST Services, LLC

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Prior Evaluation Therapy Request

Today's Date: _____

Child's Name _____DOB _____

Primary Care Physician _____

Insurance Provider _____

Date of Evaluation _____ **(Must be within the last 6 months)**

Evaluated by/at _____

Diagnosed with:

_____F80.9 Developmental disorder of speech and language, unspecified

_____F80.2 Mixed receptive-expressive language disorder

_____F80.0 Articulation Disorder

_____F80.81 Childhood onset fluency Disorder

_____F80.4 Speech and language development delay due to hearing loss

_____F84.0 Autism

_____other

_____ I don't know