SAN FRANCISCO STATE UNIVERSITY
COMMUNICATIVE DISORDERS CLINIC

**F-25: RECOMMENDATION FOR CLIENT**

Client Name: ______________________________ File Number: ______________________________

Disorder: ______________________________ Clinician: ______________________________

Supervisor: ______________________________ Date of Recommendation: __________________

**RECOMMENDATION of clinic CD 880 CD 884 (Please circle the appropriate clinic)**

☐ Therapy is not recommended for client

☐ The client is recommended for (disorder) _________________ therapy for (semester) ______________ 20____.

☐ Client is not recommended for therapy at SFSU ARCHIVE file

☐ It is the opinion of the Communicative Disorders staff that the client continue to receive therapy. However, the client or parents have decided to terminate for the following reasons: (Use back of page if necessary)

☐ The client should be contacted for therapy for _________________Semester, 20______

☐ The client should be contacted for a REEVALUATION during the ________________Semester, 20_____

☐ The client did NOT successfully complete therapy but should not return to the clinic for the following reasons:

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

**Please Record the Client's current mailing address and telephone contact information**

Client's Name: ______________________________________

Address: ______________________________________

______________________________________

Telephone: ______________________________________

Guardian / Parent's Name:

Client/Parent Signature:__________________________________________________ DATE:_________________

ADDITIONAL SCHEDULING OR OTHER INFORMATION:

Supervisor's Signature:___________________________ Clinician's Signature:___________________________