SCHOOL BASED REHABILITATION SERVICES

Speech-Language Pathologist Referral Form

1240 Murphy Road Sarnia, ON N7S 2Y6
519-542-3471 TOLL FREE 1-855-542-3471 FAX 519-542-4115
www.pathwayscentre.org

***Please attach any professional reports and submit with Principal Referral form**

STUDENT INFORMATION:		
Name:	**Date of Birth:** *(dd/mm/yyyy)*	
School:	**Grade:**	**Classroom Number:**
Resource Teacher:	**Email:**	
Teacher:	**Email:**	
Strengths/Interests and Favourite Qualities of Student (Required):		

GENERAL HISTORY:	
Date of Assessment:	
Hearing	☐ WNL ☐ History-Ear Infections ☐ Recent Hearing Test - Date:
Language Development	☐ WNL ☐ Delayed/Disorder ☐ Not Assessed Is the student receiving treatment for language issues from the School Board SLP? ☐ No ☐ Yes If yes please describe:
List all diagnoses, conditions, behaviours and other factors that may be expected to impact Speech Language therapy:	

REASON FOR REFERRAL: (Select all that apply and provide additional information)

☐ **Voice Concerns** **Referral to SBRS can be processed as long as referral to an ENT has been initiated**

Referral has been made to Ear/Nose/Throat Physician or Voice Clinic* ☐ Yes ☐ No
Referral to (Physician Name): Date Referral Faxed to ENT:

Voice Quality:	☐ WNL	☐ Difficulties
Pitch/Intonation:	☐ WNL	☐ Difficulties
Volume:	☐ WNL	☐ Difficulties
History of Vocal Abuse:	☐ Yes	☐ No
Surgery:	☐ Yes	☐ No

Vocal Nodules: ☐ Yes ☐ No

☐ **Resonance**

Involved with or referral initiated to Cleft Lip/Cleft Palate/VPI Clinic ☐ Yes ☐ No

☐ Hypernasal ☐ Hyponasal ☐ Mixed Nasality
☐ Nasal Air Emission ☐ Generalized ☐ Phoneme/Sound Specific

Additional Comments:

☐ **Fluency Concerns**

Level of Severity: ☐ Mild (3-4%) ☐ Moderate (5-8%) ☐ Severe (9-12%) ☐ Profound (>13%)
Dysfluencies Observed/Reported: ☐ repetition ☐ prolongation ☐ blocking ☐ filler
Secondary Behaviours Observed: ☐ eye tension ☐ facial grimace ☐ lip pressing ☐ nostril flare
☐ jaw jerk ☐ extra head/body movements ☐ noisy or dysrhythmic breathing

Additional Comments:

☐ **Articulation/Phonology Concerns**

Mild (Not Eligible)	• 7-16% (GFTA-3) • Intelligible most of the time (80%)

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Speech-Language Pathologist's Referral

Student Name: _____ D.O.B. _____

☐ Moderate	☐ 2-6% (GFTA-3) ☐ Intelligible 50-80% of the time (grade 2 and older)
☐ Severe	☐ <2% percentile (GFTA-3) ☐ Intelligible less than 50% of the time (grade 2 and older)

☐ Lateral Lisp: (provide examples of phonemes affected)

Check all that apply:

☐ Fronting ☐ Backing ☐ Stopping ☐ Cluster Reduction ☐ Deaffrication ☐ Assimilation
☐ Initial Consonant Deletion ☐ Final Consonant Deletion ☐ Omissions ☐ Distortions

Provide examples (sound specific substitutions):

☐ **Motor Speech**

☐ Limited vowel repertoire
☐ Difficulties with jaw, lip and tongue movements
☐ Feeding concerns (chewing& swallowing difficulties)
☐ Limited syllable/word shapes
☐ Imprecise Speech
☐ Difficulty sequencing sounds

Provide examples:

Feeding

** School teams in need of support with feeding strategies for students can contact Pathways Health Centre to check eligibility for Children's Feeding Team services* http://www.pathwayscentre.org/program-service/

☐ **Non-Verbal Communication**

☐ Uses Augmentative Communication
☐ Pathways ACS Program Referral Initiated
☐ Involved with Pathways ACS Program
☐ Previously Involved with Pathways ACS Program

Augmentative and Alternative Communication

**School teams in need of support with low/high tech communication strategies for students who require support with functional communication can contact Pathways Health Centre for Children's Augmentative Communication Service (ACS) Program* http://www.pathwayscentre.org/program-service/augmentative-communication-services*

Has the student received SBRS SLP previously? ☐ Yes ☐ No	**Year(s) of Service:**
Has the school been using the strategies developed by the therapist and are they still working? ☐ Yes ☐ No	
Have you connected with parents/caregivers and previous teachers to review interventions? ☐ Yes ☐ No	
What has changed? Describe in detail.	

REFERRING SLP		
Completed by:	**Date:**	
Email:	**Phone:**	**Ext:**
Signature:		

Note: Based on the concerns identified, needs will be prioritized and goals developed.