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:	

GENERAL:

Date of Assessment/Screening:

Hearing	☐ WNL ☐ History-Ear Infections ☐ Recent Hearing Test - Date: ☐ Central Auditory Processing Testing – 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 known 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 an ENT should be initiated by referring SLP*

Referral has been made to Ear/Nose/Throat Physician or Voice Clinic* ☐ Yes ☐ No

Report sent to (Physician Name):

Voice Quality:	☐ WNL	☐ Difficulties		
Pitch/Intonation:	☐ WNL	☐ Difficulties		
Volume:	☐ WNL	☐ Difficulties		
History of Vocal Abuse:	☐ Yes	☐ No	Surgery:	☐ Yes ☐ No
Confirmed 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% SS) ☐ Moderate (5-8% SS) ☐ Severe (9-12%SS) ☐ Profound (>13%SS)

Dysfluencies Observed/Reported: ☐ repetition ☐ prolongation ☐ blocking ☐ interjection

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**

Type of assessment completed (only one required): ☐ Standardized test ☐ Screener ☐ Informal speech sample

If standardized test completed results:
☐ Mild impairment (7^{th}-16^{th} percentile) (Not eligible)
☐ Moderate impairment (2^{nd}-6^{th} percentile)
☐ Severe impairment (<2^{nd} percentile)

Clinical impression:

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Speech-Language Pathologist's Referral

Student Name: D.O.B:

Check all that apply:

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

Provide examples (sound specific substitutions or distortions):

☐ **Motor Speech**

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

☐ **Non-Verbal Communication**

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*

HISTORY

Has the student received SBRS SLP previously? ☐ Yes ☐ No If Yes, complete the next three questions.

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 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.