SCHOOL BASED REHABILITATION SERVICES

Speech-Language Pathology 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 submit with Principal Referral form and attach any professional reports when applicable.**

STUDENT INFORMATION:	
Name:	**Date of Birth:** *(dd/mm/yyyy)*

The following referral criteria MUST BE MET to proceed with referral:

- ☐ Concern is related to: moderate to severe articulation, dysfluency/stuttering, motor speech, voice and/or resonance. School Board Speech-Language team support concerns related to: receptive/expressive language, mild articulation, auditory processing and literacy concerns.
- ☐ Caregiver has consented to this referral and agrees to support implementation of recommendations provided by SLP.

  If the referral is for a student in Grade 6 or above: The referral source attests that they have spoken to the student who is being referred, and the student is agreeable to the SBRS referral and will be receptive to the recommendations provided.
- ☐ Referral has been reviewed with an SLP and signed below prior to submission.

GENERAL INFORMATION:	
Name of Person Completing Form:	
Position of Person Completing Form: ☐ Teacher/RT ☐ SLP ☐ CDA ☐ Other:	
Has the student received SBRS SLP previously? ☐ Yes ☐ No	*If Yes, year of discharge*:
List all known diagnoses, conditions, behaviours and/or other factors that may be expected to impact Speech therapy supports:	
Language Supports	Involved with School Board Speech-Language team: ☐ Yes ☐ No *If yes, difficulties with*: ☐ Expressive Language ☐ Receptive Language ☐ Other: Date of most recent School Board SLP Assessment/Screening (if applicable):
Hearing	☐ WNL ☐ Recent Hearing Test/Screen - Date: ☐ History-Ear Infections ☐ Central Auditory Processing Testing – Date:
Therapy Readiness	Please determine if the student is ready for SBRS intervention now, or if they would benefit from being referred later if/when their readiness skills have emerged. ☐ Student can attend to and imitate another person's actions. ☐ Student is willing to attempt productions and accept feedback. ☐ Student has sufficient expressive vocabulary to support speech intervention (i.e., at least 50 words or word approximations). Please note that if your primary concern is basic communication and/or language needs, this would be a referral to your School Board Speech-Language team for consideration.
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**

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Speech-Language Pathology Referral

Student Name: D.O.B:

REASON FOR REFERRAL:

ONLY Section A OR Section B need to be completed. Form must be signed by an SLP in Section C.

Section A - may be completed by the School Team (i.e. RT/Teacher/CDA/other) for **GRADE 1+** students with School Board or SBRS SLP sign off below in Section C.
ONLY School Board SLP can complete section A for **JK/SK** students.

☐ **Stuttering/Dysfluency**

Stuttering or dysfluency is noted by: ☐ Teacher ☐ Parent ☐ Student ☐ Board SLP

Stuttering/Dysfluencies Observed:

- ☐ Repetition (e.g. Do we have set the tay-tay-table?)
- ☐ Prolongation (e.g. I can mmmmake cookies.)
- ☐ Pauses (e.g. We have a -----dog.)

The student exhibits stuttering:

☐ In every conversation ☐ In some conversations ☐ Infrequently (e.g. when excited)

Are there physical behaviours that accompany the stutter (i.e. eye blinking, head movements, etc.): ☐ Yes ☐ No *If Yes, please describe*:

☐ **Articulation/Phonology Concerns**

I can understand the student: ☐ ALL of the time ☐ SOME of the time ☐ Rarely

Please describe the difficulties you are noticing and if possible provide 3 examples. *If you are struggling to identify the area of difficulty or the specific speech error please consult with your school board SLP.*

1.

2.

3.

Additional Comments:

Section B - completed by a School Board SLP ONLY for **JK+** students.

☐ **Articulation/Phonology Concerns**

Type of assessment completed (only one required): ☐ Standardized Test ☐ Screener ☐ Informal Speech Sample

If standardized test completed results:

- ☐ Mild Impairment (7th-16th percentile) (Not eligible)
- ☐ Moderate Impairment (2nd-6th percentile)
- ☐ Severe Impairment (<2nd percentile)

Clinical Impression:

I can understand the student: ☐ ALL of the time ☐ SOME of the time ☐ Rarely

Check all that apply:

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

Additional Comments:

☐ **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 Concerns:

- ☐ Hoarse quality ☐ Strained quality ☐ Breathy quality
- ☐ Abnormal pitch ☐ Voice tremor ☐ Abnormal intonation
- ☐ Inappropriate volume ☐ Regularly loses voice ☐ Pain when using voice
- ☐ Breaks in phonation

History of: ☐ Vocal abuse ☐ Vocal nodules ☐ Surgery

Additional Comments:

☐ **Resonance**

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

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

Additional Comments:

☐ **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

Additional Comments:

Section C - COMPLETED BY School Board or SBRS SLP ONLY: (Required)				
Reviewed by (Please Print):	**Date:**			
Email:	**Phone:** **Ext:**			
Initials/Signature:	☐ **Profound**	☐ **Severe**	☐ **Moderate**	☐ **Mild**
Any Additional Information/Comments:				

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