



SCHOOL BASED REHABILITATION SERVICES

Speech-Language Pathology Referral

Student Name:

D.O.B:

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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, headmovements, 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
 - Breathary quality
 - Abnormal pitch
 - Voice tremor
 - Abnormal intonation
 - Inappropriate volume
 - Regularly loses voice
 - Pain when using voice
 - Breaks in phonation



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Speech-Language Pathology Referral

Student Name: _____

D.O.B: _____

History of: <input type="checkbox"/> Vocal abuse <input type="checkbox"/> Vocal nodules <input type="checkbox"/> Surgery Additional Comments:
<input type="checkbox"/> Resonance
Involved with or referral initiated to Cleft Lip/Cleft Palate/VPI Clinic: <input type="checkbox"/> Yes <input type="checkbox"/> No Concerns: <input type="checkbox"/> Hypernasal <input type="checkbox"/> Hyponasal <input type="checkbox"/> Mixed Nasality <input type="checkbox"/> Nasal Air Emission <input type="checkbox"/> Generalized <input type="checkbox"/> Phoneme/Sound Specific Additional Comments:
<input type="checkbox"/> Motor Speech
<input type="checkbox"/> Limited vowel repertoire <input type="checkbox"/> Limited syllable/word shapes <input type="checkbox"/> Difficulties with jaw, lip and tongue movements <input type="checkbox"/> Imprecise Speech <input type="checkbox"/> Feeding concerns (chewing& swallowing difficulties) <input type="checkbox"/> 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:	<input type="checkbox"/> Profound	<input type="checkbox"/> Severe	<input type="checkbox"/> Moderate	<input type="checkbox"/> Mild
Any Additional Information/Comments:				

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