Interim School Therapy Services

SLP Referral Form

Student Information:

First Name: _____ **Last Name:** _____ **DOB:** _____

School: _____ **School Board:** _____

Resource Teacher: _____ **Email:** _____

Background Information (diagnoses, allergies, attendance, classroom participation, social interactions and impact of SLP difficulty, etc.):

see attached report

_____

_____

_____

_____

Clinical Observations/Assessment (any special communication or behavioural needs, motivation, attention, memory, hearing, language, equipment, etc)

see attached report

_____

_____

_____

_____

List any other services involved and attach reports regarding any specialized testing completed:

see attached report

_____

_____

_____

_____

_____   _____
School Board/ PSL   **Referring SLP/Resource Teacher (Print)***

_____   _____
Date   **Signature**

*Resource Teacher may refer and sign for L1 needs only   **Phone:** _____   **Ext:** _____

School principal or designate has agreed to this referral. (Must be checked)

Family, Legal Guardian, student has agreed to this referral. (Must be checked)

(Not required for referral from PSL)

*Specify needs and reason for referral on back of page using Program Criteria and Severity Level Definitions for SLP, 2011.

1. Articulation/Phonology

Level of Severity in single words:

    Occasional sound errors or up to 2 sound errors **according to development expectations (Not eligible)**

    3 – 5 sound errors **according to developmental expectations** OR Less than 3 sound errors, with concomitant factors
    e.g. poor volume control, oral musculature difficulties, increased rate) (Level 3 eligible)
    6 or more sound errors **according to developmental expectations** (Level 2 eligible) Also, check all that apply:
    Speech production more unintelligible than be expected based on results of single word articulation tests
    Motor Speech/Dyspraxia/Dysarthria (Level 2 Motor Planning Model eligible; see CCAC "SLP Service Delivery Model for
    Articulation" for definition). **If selected, please complete section 1.a below**

Additional Details including list of assessed single sound errors: See attached report:

1.a. Motor Speech Characteristics:

    Vowel Errors: _____ (specify number of errors)

    Difficulties with motor speech control (select all that apply)

        Range of jaw movement

        Midline jaw movement

        Solid lip contact

        Lip contact independent of jaw movement

        Lip rounding independent of jaw movement

        Lip retraction

        Producing voiced-voiceless contrasts

        Integration of jaw and lips

    Limited consonant repertoire

    Persistent early developing process or atypical processes (eg. Backing, syllable deletion, initial consonant deletion, etc.)

    Limited syllable/word shapes

    Inconsistent productions

    Groping

    Atypical quality or rate of speech

    Atypical prosody

Intelligibility rating (to familiar and unfamiliar listeners)
        Understood in conversation 75% of the time
        Understood in conversation 50% of the time
        Understood in conversation 25% of the time

Client has the appropriate receptive and expressive language skills required for successful therapy
        Yes   No

Client has the intent to communicate verbally
        Yes   No

Client has the attention, motivation and ability for successful participation.
        Yes   No

2. Fluency

Level of Severity

3%-10% frequency of stuttering events. Words stuttered are fleeting, absent or barely visible to casual observer. (**Not eligible**)

11% -25% frequency of stuttering events. Words stuttered are noticeable, with a duration of half a second or more. (Level 3 eligible)

>25% frequency of stuttering events. Words stuttered are distracting, with a duration of 3 or more seconds. (Level 2 eligible)

Additional Details: See attached report

_____
_____
_____
_____
_____
_____
_____

3.   Voice/Resonance   Post-Surgical SLP Needs

Parents directed to contact physician for   ENT assessment   cleft palate team   Date_____
Level of Severity of Impact on Daily Communication: Mild   Moderate   Severe
Additional Details: See attached report:

_____
_____

4.   Swallowing and Feeding

Past Assessment_____   Unknown
Past Treatment_____   Unknown
Additional Details: See attached report:

_____
_____

5.   Non-Speech/Augmentative Communication (AC)

AC needed to express basic needs   Referral to ACS initiated   Involved with ACS
Type of System Used: _____
Additional Details: ☐ See attached report:

_____
_____

cc: School Principal to share with school team/OSR