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School Based Rehabilitation Services
Enabling Participation, Socialization and Learning

SLP Referral Report

Referrals for speech and language services are to come from an SLP with input from parent and teacher/school.

Student's Name:	Date of birth:
School:	Name of SLP:

Reason for referral: *(check all that apply)*

Articulation:	Motor Speech	Articulation/Phonological Delay	Moderate	Severe
	Cognitive delays	Lateralization	Unstimulable "R"	
Voice:	Post surgical	Severe/Moderate	Mild	
Fluency:	Mild	Moderate	Severe	
Resonance:	Post surgical	Mild/Moderate/Severe		
Feeding/Swallowing				

Has the child seen by an ENT or been referred to an ENT? Yes No Unknown

If "Yes", where/by whom? *(include report from ENT if available)*

PLEASE NOTE: If the referral is for voice or resonance, the child MUST be referred to an ENT.

Has the child had a recent hearing test? Yes No Unknown

Does the child have any known diagnosis? Yes No Unknown

If "Yes," please specify, including known source making the diagnosis.

PLEASE INCLUDE any available reports verifying the diagnosis

***Confounding variables** (i.e. language delay, attention behavioural issues, safety plan?):

ATTACH applicable reports if available

***Will the school board speech and language pathologist remain involved?** Yes No

If "Yes," indicate the services to be received and from whom:

Is a CDA involved? Yes No If "yes," whom:

Parent goals <i>(please do not exceed 4 lines of text):</i>	Teacher/school goals <i>(please do not exceed 4 lines of text):</i>
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Print Name: _____ **Agency:** _____

***Signature:** _____ ***Date:** _____