Quinte Children's Treatment Centre QHC

265 Dundas Street E.
Belleville ON K8N 5A9
Tel: (613) 969-7400 ext. 2784
Fax: (613) 961-2517

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:** Day Month Year

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 *(please do not exceed 4 lines of text)*:	**Teacher/school goals** *(please do not exceed 4 lines of text)*:

Print Name: **Agency:**

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

Last updated 12 Feb 2019