TURTLE RIVER SCHOOL DIVISION
SPEECH-LANGUAGE REFERRAL

Date of Referral: _____
School: _____
MET #: _____

Student's Last Name: _____ Student's First Name: _____

Date of Birth: _____/_____/_____ Gender: _____ Age: _____ Grade: _____ Teacher: _____
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Physician: _____ Referral Initiated by: _____ Languages Spoken in Home: _____

Please fill out address information for whoever has legal/shared custody.

Mother/Guardian Information:	**Father/Guardian Information:**	**Agency/Guardian Information:**
Last Name	Last Name	Agency Name
First Name	First Name	Case Worker Name
Street # & Name, Box # or RR and Comp	Street # & Name, Box # or RR and Comp	Street # & Name, Box # or RR and Comp
Town/City	Town/City	Town/City
Postal Code	Postal Code	Postal Code
Phone #	Phone #	Phone #

Date an Results of School Vision Screening: _____

Date and Results of School Hearing Screening: _____

Reason for Referral:

Please check issues of concern to you regarding this student's communication skills.

- ☐ Articulation/Phonology
- ☐ Cognitive Orientation (i.e. pre-language skills, lifeskills)
- ☐ Pragmatics (i.e. social-language)
- ☐ Voice Production
- ☐ Hearing Aids/Assistive Listening Devices
- ☐ Phonological Awareness
- ☐ AAC Comprehension
- ☐ AAC Production
- ☐ Language Comprehension
- ☐ Language Production
- ☐ Fluency/Rate/Rhythm
- ☐ Deaf and Hard of Hearing

Please elaborate on these concerns:

_____

_____

_____

Does this student experience other difficulties, which influences his or her learning abilities (i.e., academic, behaviour, physical, cognitive, medical conditions, hearing, vision, etc.)?

_____

_____

_____

What are this student's strengths/skills?

_____

_____

What additional testing has been completed with this student?

_____

_____

What strategies or interventions have been tried to help improve this student's communication skills (i.e. modeling of appropriate sound production or word usage, language experience activities, resource assistance, etc.)?

_____

_____

What are your expectations from this referral?

- ☐ Assessment only to determine functional level
- ☐ Assessment with follow-up programming suggestions

What type of supports will the school and home commit if the student requires a specific programming?

- ☐ Educational Assistant Time
- ☐ Consultation Time
- ☐ Regular Parent/Child Interactions At Home

Please list additional significant information, parent concerns, and/or comments:

_____

_____

_____ Resource Teacher Signature

_____ Classroom Teacher Signature

_____ Principal Signature

_____ Parent/Guardian Signature

_____ Student Services Administrator Signature

White - School Copy *Yellos - Clinician Copy* *Pink - File Copy*