SCHOOL BASED REHABILITATION SERVICES (SBRS)

Speech Language Pathology Additional Referral Information

Student's Name: _____ Date of Birth: _____

School Name: _____ Class Grade: _____

Reason for Referral:

☐ Articulation/Phonology/ Motor Speech/Dyspraxia – Please specify:
- ☐ Severe (7 or more sound errors)
- ☐ Moderate (4 - 6 sound errors)
- ☐ "r" sounds - must be age 7 and older
- ☐ Interdental/Frontal Lisp – must be age 8 and older
- ☐ Lateral Distortion / Lisp

☐ Fluency
☐ Voice – must be accompanied by an ENT Report completed within last 6 months and enclosed with the referral
☐ Resonance: Please attach any applicable reports
☐ Feeding/Swallowing (joint assessment with OT required)
☐ Is this a re-referral to SHSS/SBRS? ☐ Yes ☐ No

Therapy Readiness Skills:

The student is required to have the following therapy readiness skills listed below before an SBRS referral can proceed. Please determine if the student is ready for SBRS intervention now, or if they would benefit from being referred at a later time if/when their readiness skills have emerged. For help to guide such conversations with parents and teachers, you may wish to use the *Therapy Readiness Skills for SBRS SLP* tool.

Behavioural Readiness

☐ The student is able to sit and attend for the length of time needed for intervention to be effective (25-30 min)
☐ The student is able imitate speech sounds/movements with mouth
☐ The student is able to follow an adult's agenda, not their own, and transition out of the classroom easily

Language Readiness

The student has the language skills to support the recommended intervention, including:
☐ Receptive language skills strong enough to support understanding of simple directions, cueing, and feedback
☐ Enough expressive vocabulary to support speech intervention (i.e. at least 50 words or word approximations)
☐ Understanding that communication is a two-way street, and can take turns with an adult

If communication and basic language is the priority area of need (i.e. see language readiness skills), a referral for SBRS should be deferred until they are further developed.

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Background Information	
Hearing: ☐ History of Ear Infections ☐ Recent Hearing Test ☐ Not Known **Comments:**	
Language Development: ☐ Delayed/Disordered ☐ Within Normal Limits (WNL) ☐ Not Assessed	
Is the child/youth receiving treatment for language issues from the School Board SLP? ☐ Yes ☐ No	
If yes, what kind of intervention is the student receiving?	
Has the school board completed a language assessment, and is a report available? ☐ Yes ☐ No Comments	

Has the child/youth received SLP Assessment/Therapy in the past? ☐ Yes ☐ No ☐ Info not available

AGENCY	NAME OF THERAPIST	APPROXIMATE DATES

ARTICULATION / PHONOLOGY / MOTOR SPEECH / DYSPRAXIA

Level of intelligibility connected speech:

☐ More Than 80% ☐ Between 50%-80% with Careful Listening

☐ Less than 50% of the time with Familiar Listeners and Known Context

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Phonological Processes/ Articulation Errors (Specify Errors)

- ☐ Fronting _____
- ☐ Backing _____
- ☐ Stopping _____
- ☐ Vowel Distortion _____
- ☐ Weak Syllable Deletion _____
- ☐ Cluster Reduction _____
- ☐ Deaffrication _____
- ☐ Gliding _____
- ☐ Final Consonant Deletion _____
- ☐ Initial Consonant Deletion _____
- ☐ Omissions _____
- ☐ Distortions _____
- ☐ Substitutions _____
- ☐ Other _____

Motor Speech Function: ☐ Difficulty Sequencing ☐ Imprecise Speech ☐ Effortful Groping ☐ Drooling ☐ WNL

Describe: (e.g. jaw grading and/or lateralization, lip rounding/retraction, tongue control, etc.)

FLUENCY: ☐ Mild ☐ Moderate ☐ Severe

Age of Onset:
Describe:

Secondary Characteristics	
Impact on student's self-esteem/participation in school	

VOICE/RESONANCE ☐ Mild ☐ Moderate ☐ Severe

Voice Quality		Pitch	
Intonation		Volume	

History of Vocal Abuse ☐ Yes ☐ No Vocal Nodules ☐ Yes ☐ No

Surgery	

Parents have a copy of ENT Report ☐ Yes ☐ No *(must be disclosed by parent to qualify for **voice** services. If you cannot provide: Intake from SBRS services will follow up to request ENT report from parent)*

Resonance ☐ Hypernasal ☐ Hyponasal ☐ Nasal Air Emission

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Cleft Palate	☐ Yes ☐ No	**Involved with Cleft Palate Team / VPI Team**	☐ Yes ☐ No
	Which Team (if available):		
☐ Uses Augmentative Communication			
☐ Involved with Augmentative Team			

Any teacher comments or pertinent information pertaining to this referral:

School Board _____

SLP Name _____ **SLP Signature** _____

Phone _____ **Ext** _____ **Date** _____