SPEECH AND LANGUAGE REFERRAL FORM

Meade School District 46-1
Sturgis, South Dakota 57785
Telephone (605)-347-4770 Ext. 4
Fax (605)-347-8089

Date of Referral: _______________

Student's Name: ____

Date of Birth: _________________ Age: _________ Male/Female: ___________

Parent/Guardian Name(s): ____

Home Phone: ___________ Cell Phone: ____________ Work Phone: ___________

Address: ____

Person submitting the referral: ____

Relationship to the child: ____

Speech and Language Concerns:
Please check (✓) all that apply to the student.
Compared to students of similar age and grade, the student ____________.

Speech (articulation):
____ difficulty pronouncing certain sounds
____ has unclear speech

Language:
____ has a limited vocabulary
____ has difficulty expressing needs
____ uses incomplete/incorrect sentences
____uses incorrect grammar
____ needs instructions repeated often
____ doesn't follow multi-step directions
____ doesn't recall day to day information
____ has difficulty sequencing an event
____ answers inappropriately to questions

Fluency:
____ demonstrates repetitions in speech
("I want I want that book." Or I, I, I want a book.")
____ demonstrates prolongations in speech
("I nnnnnneeeed help.")
____ demonstrates a fast speaking rate
____ demonstrates blocking sounds

Voice:
____ has harsh or breathy voice quality
____ voice sounds hypernasal
(sounds like the student is talking through his/her nose)
____ voice sounds hyponasal
(sounds like the student has a cold)

Pragmatics (social communication skills):
____ has difficulty using gestures
____ doesn't respond to facial expressions
____ has no eye contact when spoken to
____inappropriate comments, answers, etc.

Additional Concerns:

Please provide specific examples of behaviors by the student:

To Be Completed by the School District

____ Student was observed by professionals. There is no need for an evaluation at this time.

____ An evaluation should be completed at this time and parental consent must be obtained.

______________________________ ______________
Therapist's Signature Date

______________________________ ______________
Administrator's Signature Date