Greater Victoria School District Speech Language Pathology Services

Dear Parents,

A referral for Speech Language Pathology Services has been requested for your child by their teacher and/or the school based team. The purpose of this letter is to provide you with information about Speech and Language services provided in our schools.

The aim of the Speech Language Pathology program in our schools is to support students in acquiring communication skills central to academic achievement, social development and interaction, and successful independent functioning.

SLP services may be provided to address one or more of the following areas of communication:

* Speech Sound Production / Articulation
* Language development – understanding and using spoken language
* Voice Quality
* Fluency (stuttering)
* Augmentative and Alternative Communication
* Phonological / Phonemic Awareness
* Social Communication

Children referred for our services may receive one or more of the following types of services:

* Assessment / evaluation of communication skills
* Consultation with school staff, family members and outside agencies (with parent permission)
* Home Programs
* Support for development of communication goals within an IEP, if applicable
* Direct instruction (individually or in groups or in the classroom)
* Collaboration with school staff and outside agencies (with parent permission)
* Staff training in support of a student’s communication challenges
* Monitoring needs and progress

Important information about our services:

* Services are provided at school.
* We strive to begin services within three months of receiving a referral. Due to large caseload sizes, there may be a wait time between the time of referral and the time services begin.
* Duration of direct instruction may vary based on student needs and caseload demands.
* Once the referral has been processed, a speech and language file on the student will be opened and maintained until the student is discharged from the caseload and the file is closed..
* Once a child has been referred and services initiated, a written report will be provided to parents and the school at least once per school year.
* Reports and information will not be shared with outside parties without parent consent
* Students referred after spring break may not be seen until the following school year.
* Speech and language files will be closed when a student has achieved their goals and/or when they move to middle or high school or move out of the district.
* Parents can decline or discontinue speech and language services at any time.

If you are in agreement with this referral being made, please add your signature in the appropriate places and return the form to your child’s school. If you have any questions, please contact your child’s teacher.

**REFERRAL FOR ASSESSMENT**

For Office Use Only:

🞏 History

🞏 Referrals

🞏 Scanned

**REFERRAL FOR SLP, VI AND/OR DHH ASSESSMENT**

**STUDENT INFORMATION:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Student Name: |  | |  | | |
|  | LASTNAME | | FIRSTNAME | | |
| PEN # (9 digits): |  | Date of birth: |  |  |  |
|  |  |  | MONTH | DAY | YEAR |
| School: |  | Grade: |  | | |
| Teacher: |  | Referred by: |  | | |

**PARENT/LEGAL GUARDIAN CONTACT INFORMATION:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Parent/Guardian(s): |  | | | | Home Phone: | |  | |
|  | LASTNAME/FIRSTNAME | | | |  | | | |
| Relationship: |  | Cell Phone: | |  | | Work phone: | |  |
| Address: |  | | Postal Code: | |  | | | |
| E-mail address: |  | | | | | | | |

**ASSESSMENT SERVICE(S) REQUESTED:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Speech & Language Pathology (SLP) Services |  | Itinerant Teacher Services (VI/DHH) |

**SERVICES THIS STUDENT HAS ALREADY RECEIVED and/or IS RECEIVING:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | When was service provided? | Who provided service? | How long? |
|  | Learning Assistance/Resource Room |  |  |  |
|  | English Language Learner (ELL) |  |  |  |
|  | School Counselling |  |  |  |
|  | Psychology |  |  |  |
|  | Speech & Language (SLP) |  |  |  |
|  | Occupational Therapy (OT) |  |  |  |
|  | Physiotherapy (PT) |  |  |  |
|  | Child/Youth Mental Health |  |  |  |
|  | Other Services: |  |  |  |

1. **PARENT CONSENT FOR SERVICES REQUESTED (Signature required)**

**Note: Signatures are required for each service requested.**

|  |  |  |
| --- | --- | --- |
|  | **SPEECH AND LANGUAGE PATHOLOGY (SLP) SERVICES** | |
|  | **Reason for Referral:** |  |

­**PARENT CONSENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_**

**Month Day Year**

**PARENT CONSENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_**

**Month Day Year**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **ITINERANT TEACHER SERVICES** | | | |
|  |  | **VISUALLY IMPAIRED** |  | **DEAF AND/OR HARD OF HEARING** |

**PARENT CONSENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_**

**Month Day Year**

**PARENT CONSENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_**

**Month Day Year**

1. **INFORMED CONSENT FOR SERVICE: (Signature required)**

I,  am the parent/legal guardian of **.**

My signature following the reason for referral (see above) indicates my consent to have the specialist(s) listed above provide services to my child.

The nature and purpose of these services have been discussed with me by: (School-based team member).

I understand that the services and educational plans arising from the assessment provided by the specialist(s) can be discussed with me and that a copy of subsequent reports can be made available at my request.

I also understand that a copy of the report(s) prepared by the specialist(s) identified above, will be sent to the school and placed in the student’s file. The school copy of the report will be available to school personnel authorized to provide educational services to this student.

**PARENT CONSENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_**

**Month Day Year**

**PARENT CONSENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_**

**Month Day Year**

1. **SCHOOL ADMINISTRATOR (Signature required)**

|  |
| --- |
| **THIS FORM IS COMPLETE AND REQUIRED DOCUMENTS ARE ATTACHED:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_**  **SIGNATURE OF SCHOOL ADMINISTRATOR Month Day Year** |
|  |