

# Referral for Speech Therapy

Tunica County Schools

School: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_

Name: \_\_\_\_\_

Grade: \_\_\_\_\_

Referring teacher: \_\_\_\_\_

RECEPTIVE LANGUAGE		<input type="checkbox"/> Difficultly comprehending new Ideas	<input type="checkbox"/> Does not follow multi-step verbal directions	<input type="checkbox"/> Does not comprehend questions
<input type="checkbox"/> Does not understand/follow spoken directions	<input type="checkbox"/> Cannot identify simple objects	<input type="checkbox"/> Does not understand vocabulary words related to curriculum	<input type="checkbox"/> Does not understand information in class that is presented orally	<input type="checkbox"/> OTHER (Please specify):
<input type="checkbox"/> Does not demonstrate use of position words: on, under, front, behind, beside, over	<input type="checkbox"/> Does not understand age appropriate vocabulary words			
EXPRESSIVE LANGUAGE		<input type="checkbox"/> Difficultly organizing thoughts	<input type="checkbox"/> Hesitant to engage in verbal interaction	<input type="checkbox"/> Does not use spoken compound sentences
<input type="checkbox"/> Nonverbal	<input type="checkbox"/> Uses immature words/sentence patterns	<input type="checkbox"/> Silent much of time	<input type="checkbox"/> Does not utilize age-appropriate grammar	<input type="checkbox"/> Cannot retell a story
<input type="checkbox"/> Uses oral grammar incorrectly	<input type="checkbox"/> Difficultly asking questions	<input type="checkbox"/> Difficultly finding the right words	<input type="checkbox"/> Difficultly telling a story	<input type="checkbox"/> Does not name objects/actions in pictures
<input type="checkbox"/> Verbal responses do not relate to questions asked/subject under discussion	<input type="checkbox"/> Verbal responses do not relate to questions asked/subject under discussion	<input type="checkbox"/> Does not tell definitions of words	<input type="checkbox"/> Difficultly putting thoughts down on paper	<input type="checkbox"/> OTHER (Please specify):
<input type="checkbox"/> Verbal responses do not relate to questions asked/subject under discussion				
SPEECH				
ARTICULATION		VOICE		OTHER
<input type="checkbox"/> Substitutes one sound for another	<input type="checkbox"/> Omits sounds	<input type="checkbox"/> Too loud or too soft	<input type="checkbox"/> Consistently hoarse/harsh/breathy	<input type="checkbox"/> If additional characteristics are noted in any area of speech, please specify:
<input type="checkbox"/> Distorts sounds	<input type="checkbox"/> Difficultly sequencing sounds	<input type="checkbox"/> Nasal sounding - like a constant cold	<input type="checkbox"/> Pitch too high or too low	
<input type="checkbox"/> Difficult to understand	<input type="checkbox"/> Able to self-correct errors	<input type="checkbox"/> Voice "lost" by end of or during day	<input type="checkbox"/> Quality makes difficult to understand	
<input type="checkbox"/> Uses dialect		<input type="checkbox"/> Quality resulting from culture		
FLUENCY				
<input type="checkbox"/> Rate of delivery too fast or too slow	<input type="checkbox"/> Disruption in normal flow of speech			
<input type="checkbox"/> Words prolonged	<input type="checkbox"/> Excessive repetition of syllable/sound/word			
<input type="checkbox"/> Interferes with daily communication	<input type="checkbox"/> Inserts unnecessary words into speech			

## Action taken by speech therapist:

\_\_\_\_\_ *informal screening* date \_\_\_ / \_\_\_ / \_\_\_

\_\_\_\_\_ *standardized screening* date \_\_\_ / \_\_\_ / \_\_\_

\_\_\_\_\_ *Other(explain)*  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_