Grandview School District Special Education
REFERRAL FORM- SPEECH ONLY

Name of Student: ______________________ **Grade:** ______________________

Age: __________ **Birth Date:** ______________________ **Sex (check one)** ☐Male ☐Female

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Referred by: ______________________ **Date of referral**: ______________________

School: ______________________ ***Teacher:*** ______________________

Sign Language/Interpreter Needed? ☐Yes ☐No **Home Language:** ______________________

Parents prefer written communications in: ☐English ☐Spanish ☐Other: ______________________

Parent/Guardian Name: ______________________ **Parent/Guardian Name:** ______________________
Mother/Guardian Name Father/Guardian Name

Parent Address: ______________________

Phone: ______________________ Cell**:** ______________________

Surrogate Needed? ☐Yes ☐ No **Name:** ______________________

Pre-Referral Meeting:

Date of pre-referral with the parent: ______________________

What was the outcome from these services? ______________________

Was this a person-to-person conference or telephone conference? ☐Person-to-person ☐Telephone

Name of Person who conducted the conference: ______________________

Parent Input: ______________________

SPEECH AND / OR LANGUAGE CONCERNS (check all that apply):

☐Unusual Voice quality (pitch, hoarseness, loud / weak voice, etc...)

☐Stuttering (hesitation, repetition of words, evidence of struggle when speaking)

☐Inappropriate use of language (incomplete sentences, limited vocab, incorrect word order…)

☐Limited language comprehension (trouble following directions, off-target responses to questions)

☐Errors in speech sounds

Specific language concern:______________________

Examples of student's speaking deficits: ______________________

Adverse impact on education: ______________________

Prior Services:

Please list any prior services (i.e. counseling, therapy) the student has received that you know of, including dates:

____

Current reading level or group? ____

When did this student enter Grandview School District? ______________________________

Was there a previous Special Education referral? ☐**Yes** ☐ **No** **When?** ______________________

What was the outcome? ____

Completed by School Nurse:

Sensory and Health Screening Information: Please attach any developmental information or health information which is relevant to this referral.

Vision Date(s): ______________________ **Corrective Lenses:** ☐Yes ☐No

SCREENING INFORMATION - Health Screening (attach developmental history, if appropriate)

Vision: Date:

BOTH	RIGHT	LEFT
WO 20/_____ W 20/______	WO 20/______ W 20/______	WO 20/_______ W 20/________

Hearing:

Date: Click or tap here to enter text. **A/C:** Click or tap here to enter text.**B/C:** Click or tap here to enter text.

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R						
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Specific health Concerns: ____

Other screening results: ____

Screening Conducted By: ______________________ **Title:** ______________________

Signature: ____________________________________

Designated representative of Grandview School District: ______________________ **Date:** __________

Principal Signature: ____________________________________ **Date:** __________

SCHOOL DISTRICT DECISION REGARDIMG WHETHER OR NOT TO EVALUATE (***Office Only***)

After reviewing this referral, the following decision has been made by the School District:

☐Seek consent to provide a Special Education evaluation for this student.

☐A Special Education evaluation would not be appropriate at this time. There is not adequate evidence to suspect a disability which would adversely affect academic performance - with or without accommodations.

☐PWN attached to referral form if not proceeding with evaluation.

Speech Language Pathologist__________________________________ **Date:** ___________________