SUWANNEE COUNTY SCHOOL DISTRICT

Office of Student Services
1740 Ohio Avenue, South Live Oak, Florida 32064

Speech Referral Process

Student: **Teacher:** **Grade:**

When a teacher/parent/staff member requests a screening for Speech, they bring their concerns to the Student Support Team.
Complete the Checklist Below for a Speech Referral

☐ A Conference/Meeting Summary Form is completed by the teacher/school counselor, noting the Speech concern(s).
(Note on Conference Form if meeting was a phone conversation or in-person meeting)

- ☐ Stated on Form, "Parent gives permission for the **SLP** to conduct a screening/observation of student."
- ☐ Stated on the Form, "Parent gives permission for the **School Nurse** to check Hearing/Vision."

☐ **School Counselor** has given School Nurse Hearing/Vision "Sensory" screening form _____*(Date)*

- ☐ Student PASSED Hearing/Vision screening_____*(Date Passed)*
- ☐ Student FAILED Hearing/Vision screening_____*(Date Failed)*
  - ☐ **Nurse** contacted parent regarding FAILED Hearing/Vision _____*(Date Called)*
  - ☐ **School Counselor** should follow-up with parent until Hearing/Vision is corrected and notify the **SLP**

☐ **School Counselor** gives the classroom teacher the "Teacher Checklist-Speech" and the "Speech Referral Form" to complete.

- ☐ "Speech Referral Form"_____*(Date Given to Teacher)* _____*(Date Returned)*
- ☐ "Teacher Checklist-Speech"_____*(Date Given to Teacher)* _____*(Date Returned)*

Guidance will turn packet over to SLP to screen/observe the student. SLP will share findings with School Counselor.

☐ If student **passes** the screening and NO further evaluation is needed - **SLP** will contact the parent to review screener.

- ☐ **SLP** contacted and reviewed screener with parent/guardian. _____*(Date Notified)*
- ☐ **SLP** returns referral to **School Counselor.** _____*(Date Notified)*
- ☐ **School Counselor** notified **Staffing Specialist.**_____*(Date Notified)*
- ☐ **Staffing Specialist** sent Prior Written Notice & Procedural Safeguards to parent/guardian._____*(Date Notified)*
- ☐ **Staffing Specialist** returns to School Counselor to place in Cumulative Folder. _____ *(Date Notified)*

☐ If student **fails** the screening and further evaluation is needed.

- ☐ **Non-ESE student - School Counselor** meets with parent to get CONSENT for further **Speech** evaluation_____*(Date)*
- ☐ **ESE student - Staffing Specialist** meets with parent to get CONSENT for further **Speech** evaluation _____ *(Date)*
- ☐ **School Counselor/Staffing Specialist** scan to Administrative Secretary of Student Services @ District Office & SLP _____ *(Date Sent)*

☐ The School's SLP will complete the Speech evaluation and share finding with District Office Staffing Specialist.
SLP remember if the student is Pre-K/VPK inform District Pre-K Evaluator for Child Outcome Measures

The District Office Staffing Specialist will schedule an eligibility meeting to review the SLP's findings.

Suwannee County School District

Parent/Guardian Conference Documentation

DATE: _____ **STUDENT NAME:** _____

DOB: _____ **GRADE:** _____ **TEACHER:** _____

NOTES:

Teacher Observations/Parent or Guardian Concerns/Recommendations/Follow-Up

☐ Yes ☐ No Parent gives permission for the School's SLP to conduct a speech screening/observation.

☐ Yes ☐ No Parent gives permission for the School Nurse to check Hearing/Vision (Sensory Screening).

PARENT:

TEACHER:

OTHER:

SUWANNEE COUNTY SCHOOL DISTRICT

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1740 Ohio Avenue, South
Live Oak, Florida 32064
386-647-4630

Sensory Screening Form

Student:_____ **School :** _____

Teacher:_____ **Grade :**_____ **Date of Birth:** _____

Referred by: _____

Parent Signature:_____ **Date:** _____

HEARING:

Screening Completed By & Position: _____ **Date of Screening:** _____

Results: ☐Pass ☐Fail

Further Evaluation Required: ☐Yes ☐No

Comments:

VISION:

Screening Completed By & Position: _____ **Date of Screening:** _____

Results: ☐Pass ☐Fail
☐Pass w/Glasses

Further Evaluation Required: ☐Yes ☐No

Comments:

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Speech Referral Form ~ Completed by Teacher

DATE: _____ **STUDENT NAME:** _____

DOB: _____ **GRADE:** _____ **TEACHER:** _____ **ROOM#:** _____

Description of suspected problems:

Please give specific examples of how your student's speech is affecting him/her in the classroom:

☐ Yes ☐ No Does he/she have a history of health problems?	**PARENT:**
☐ Yes ☐ No Does he/she have a record of hearing problems?	**TEACHER:**
☐ Yes ☐ No Has he/she had previous therapy?	**OTHER:**
☐ Yes ☐ No Is this student enrolled in any special class?	

Suwannee County School District

Teacher Checklist ~ SPEECH

DATE: _____ **STUDENT NAME:** _____

DOB: _____ **GRADE:** _____ **SCHOOL:** _____

Teacher ~ Please complete this form and return to Guidance Counselor.

1) Student show problems pronouncing speech sound/s? ☐ Yes ~ Complete the **SPEECH SOUND** section ☐ No ~ Go to ?2

SPEECH SOUND: *(Check all that apply)*:

- ☐ The student uses gestures to help others understand what he/she is saying
- ☐ The student is easily frustrated when speaking
- ☐ The student is not easy to understand when the subject or context is unknown
- ☐ When the student speaks, the listener is more focused on the pronunciation than the message
- ☐ The student does not volunteer to speak in class
- ☐ The student has expressed concern about his/her speech, or about comments from peers
- ☐ The student's speech error have an adverse effect on his/her functioning and/or performance in the classroom, EXPLAIN

2) Do you think the student has a stuttering problem? ☐ Yes ~ Complete the **FLUENCY** section ☐ No ~ Go to ?3

FLUENCY: *(Check all that apply)*:

- ☐ The student stutters when he/she speaks in the classroom
- ☐ The student demonstrates physical characteristics of frustration when speaking
- ☐ The student avoids speaking in class and other school settings
- ☐ The student has expressed concern about his/her speech, or about comments from peers
- ☐ The student's dysfluencies have an adverse effect on his/her functioning and/or performance in the classroom
- ☐ The student has expressed concern about his/her speech, or about comments from peers, EXPLAIN

3) Do you think the student has a problem with his/her voice? ☐ Yes ~ Complete the **VOICE** section ☐ No

VOICE: *(Check all that apply)*:

- ☐ The student's voice quality (hoarse, harsh, breathy, or nasal) is noticeable and distracting to others
- ☐ The student's voice quality has been a concern over a period of time
- ☐ The student's hoarseness gets worse during the school day
- ☐ The student has expressed a concern about his/her speech, or about comments from peers
- ☐ The student's voice quality has an adverse effect on his/her functioning and/or performance in the classroom, EXPLAIN

4) Has the parent/guardian been informed of your concern(s)? ☐ Yes ☐ No

Additional Comments:

Teacher's Signature: _____