**Suwannee County School District**
**Office of Student Services**
**Documentation of Pre-Referral Activities for ESE Referral**

| Student Name | Grade | DOB | School Name |
|---|---|---|---|
| | | | |

Teacher: ____________________________________

**Concerns:**

Speech ☐

**Previous Referral of Evaluation:** ☐ Yes No ☐

**Parent Conference Dates:** (1) ______________________ (2) _____________________
*(Any meetings attended by parent)*

**Intervention Document Worksheet attached:** ☐ Yes ☐ No
*(Referral will not be processed without this attachment)*

**Behavioral Observation Dates:** (1) ______________________ (2) _____________________
*("Speech only" referrals need classroom checklist. Gifted requires no observation. ALL others MUST include at least one observation completed/dated AFTER consent for evaluation is signed.)*

**SST Meeting Dates:** (1) ______________________ (2) _____________________
(3) ______________________ (4) _____________________
*(Gifted only needs one meeting. "Speech only" requires one SST.)*

**Sensory Screenings:** (5200-006) Consent must be signed by parent prior to screenings.
Screening consent date: _______________________

(1)Vision Date ___________ ☐ Pass ☐ Fail (3) Speech Date ___________ ☐ Pass ☐ Fail
(2) Hearing Date _________ ☐ Pass ☐ Fail (4) Language Date _________ ☐ Pass ☐ Fail

***For Emotional / Behavioral referrals only, include FBA/BIP.** Date of BIP ___________________

Parent Consent to Evaluate (5200-011) Date signed: _________________________
*(Referral MUST be received at the Student Services within 10 days of signed consent.)*

**Suwannee County School District**
**Office of Student Services**

**Meeting Summary Sheet**

**Meeting Date:** ____________________

| Student Name | Grade | DOB | School Name |
|---|---|---|---|
| | | | |

**Notes:**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Summary:**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Team Recommendations:** ☐ **Yes** ☐ **No**

**Continue current interventions**
**Implement additional interventions**
**Refer for further evaluation**

| Team Member Signatures | | Position/Role |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Suswannee County School District**
**Office of Student Services**
**Speech Referral Form**

**School:** ______________________________________ **Room:** ____________________

**Teacher:** _____________________________________ **Date:** _____________________

**Grade:** _______________________________________

**Student's Full Name:** ______________________________________________________

**Birthdate:** ________________________________________

Description of suspected problems:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Other pertinent data:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Is this student enrolled in any special class? ☐Yes ☐No

Does he/she have a history of health problems? ☐Yes ☐No

Does he/she have a record of hearing problems? ☐Yes ☐No

Has he/she had previous therapy? ☐Yes ☐No

_________________________________________
Teacher Signature

_________________________________________
Parent Signature

_________________________________________
Other

## Educational Relevance of the Communication Disorder

______________________________

***Name of Student***

Does / does not demonstrate a communication disorder that does/does not negatively impact his/her ability to benefit from the educational process in one or more of the following areas:

**Academic** – ability to benefit from the curriculum
**Social** – ability to interact with peers and adults

| Academic Impact | Social Impact |
| --- | --- |
| List academic areas impacted by communication problems:<br>______________________________<br>______________________________<br>______________________________ | List social areas impacted by communication problems:<br>______________________________<br>______________________________<br>______________________________ |
| ☐ Below average grades<br><br>☐ Inability to complete language-based activities vs. non-language based activities<br><br>☐ Inability to understand oral directions<br><br>☐ Grades below the student's ability level<br><br>☐ Other | ☐ Peers tease student about communication problem<br><br>☐ Student demonstrates embarrassment and/or frustration regarding communication problem<br><br>☐ Student demonstrates difficulty interpreting communication intent<br><br>☐ Other |

______________________________
Speech-Language Pathologist

______________________________
LEA (Designee)

______________________________
Other Professional

______________________________
Other Professional

______________________________
Parent

______________________________
Date

# Teacher Checklist - SPEECH

| Student Name | Grade | DOB | School Name |
|---|---|---|---|
| | | | |

**Teacher name:** ______________________________________________________________

**Please return completed form to:** _________________________________________________

Do you think the student has problems pronouncing speech sound? ☐ Yes ☐ No If YES, complete the SPEECH SOUND section below.

**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 errors have an adverse effect on his/her functioning and/or performance in the classroom, **if checked**,

**Explain:** ________________________________________________________________________

________________________________________________________________________________

Do you think the child has a stuttering problem? ☐ Yes ☐ No If yes, complete the FLUENCY section below.

**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, **if checked**,

**Explain:** ________________________________________________________________________

________________________________________________________________________________

Do you think the student has a problem with his/her voice? ☐ Yes ☐ No If YES, complete the VOICE section below.

**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, **if checked**,

**Explain:** ________________________________________________________________________

________________________________________________________________________________

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

Additional
Comments:__________________________________________________________________________

_______________________________________________________________________________

**Teacher Signature:**_________________________________________ **Date:** _________________________

**Suwannee County School District**
**Observations**

(Observations ***must*** be conducted during the time when the student's learning or behavioral areas of concern occur)

**Observation Date: ________________________________**

| Student Name | Grade | DOB | School Name |
|---|---|---|---|
| | | | |

**OBSERVATION SUMMARY:** ☐ **Pre-intervention Observation** ☐ **Post-intervention Observation**

**Observer / Position:** ___________________________ Start Time: _____________ End Time: ____________

Subject Area: ____________________________
Class Activity: ☐ Teacher directed whole class ☐ Teacher directed small group ☐ Independent work session
☐ Other (describe) ______________________________________________________________

Directions: Place a (X) beside the problem behaviors that were observed ***during this observation***.

| | Academic Engagement | | Attention / Organization | | Social / Behavior |
|---|---|---|---|---|---|
| | Difficulty beginning / Completing tasks | | Does not follow classroom rules | | Needs constant reassurance |
| | Gives up easily | | Does not comply to teacher direction | | Cries/pouts/ sulks |
| | Reverse / confuses letters, words, numbers | | Talks out excessively | | Acts frightened; timid/shy |
| | Does not turn in assignments | | Disorganized desk and work materials | | Withdrawn |
| | Requires teacher prompting to work | | Difficulty transitioning between tasks | | Avoided or rejected by peers |
| | Excessively seeks others' assistance | | Short attention span | | Clings to teachers or others |
| | Does not ask for assistance | | Fidgets with objects | | Nervous/excitable |
| | Does not participate in discussion / activity | | Stares blankly/seemingly daydreams | | Argumentative |
| | Out of seat or assigned work area | | Acts impulsively | | Loses temper |
| | **Language Articulation** | | **Physical Concerns** | | |
| | | | | | Picks on others |
| | Difficulty understanding written directions | | Seems tired / lethargic | | Swears / uses profanity |
| | Difficulty understanding oral directions | | Makes physical complaints | | Changes mood rapidly |
| | Difficulty understanding student's speech | | Poor fine motor coordination | | Talks disrespectfully to others |
| | Difficulty answering questions verbally | | Poor gross motor coordination | | Damages property |
| | Poor use of grammar / vocabulary | | Fidgets / squirms | | Disrupts activities / learning environment |

Narrative of observation:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Suwannee County School District**

**Sensory Screening Form**
**Speech Only Referrals**

| Student Name | Grade | DOB | School Name |
|---|---|---|---|
| | | | |

Referred By: ______________________ Teacher: ______________________

Parent Consent: ______________________________________ Date: __________

| HEARING | VISION |
|---|---|
| Passed ☐ Failed ☐ | Passed ☐ Failed ☐ |
| Comments: | Comments: |
| ______________________<br>Person Responsible/Position<br>Further Evaluation Required: ☐Yes ☐No<br>Date of Evaluation: ______________ | ______________________<br>Person Responsible/Position<br>Further Evaluation Required: ☐Yes ☐No<br>Date of Evaluation: ______________ |