School Health Professional Services Referral Form
Fax: 1-866-869-0071

IMPORTANT:

- The Principal or designate must affirm that available school resources and levels of support have been accessed prior to initiating the referral.
- The school is required to be actively involved in support of the therapy program.
- Student must have a **valid Ontario Health Card Number** to obtain CHEO services.
- If this referral is the result of another professional's recommendation (e.g. Psychologist, Ear Nose Throat Specialist), the professional's report **MUST BE INCLUDED** in this referral package.
- **Incomplete referrals will not be processed, but returned to the referral source.**
- Please retain a copy of the referral for your records.

Student Information (Print):

Student's Name:	D.O.B	☐ male ☐ female ☐
Student's Address (include city):		Postal Code:
Health Card #***(If known)***:	Version Code:	Expiry Date:
Known Diagnosis:		

Parent/Guardian Contacts:

First Name:	Phone # (H):
Last Name:	Phone # (B):
Relationship:	Phone # (C):
Address:	
First Name:	Phone # (H):
Last Name:	Phone # (B):
Relationship:	Phone # (C):
Address:	
Comments:	

☐ ***MANDATORY* Referral information has been shared with parent(s) and the referral source has received parental consent to share this information with CHEO and LHIN SHPS.**

School Information *(If known)*: (Print)

School:	Grade:
School Address:	Type of class:
School Phone:	Teacher:
School Fax:	Resource Teacher:

Specify who will be responsible for follow up on the recommendations of the provider?

☐ Teacher ☐ Special Education/Resource Teacher/LST ☐ Principal ☐ Other

Services Requested:

☐ Speech Therapy	**Refer to checklist for completing a SLP Referral.** **A Registered SLP is required to complete the referral for speech therapy.**

Referral Source Signature: _____ Date: _____

Print Referral Source _____ Contact Number: _____

CHEO

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Checklist for Completing the Speech Referral:

- ☐ Obtain written permission from parents/guardian to refer the child to the CHEO for speech services.
- ☐ Complete the School Services Application Form.
- ☐ The referring Speech Language Pathologist must complete (with signature and date), either CHEO School Speech Therapy Referral Form, or send a speech and language report that includes the same information.
- ☐ Attach a current (within one year) speech and language assessment report. A complete language report is only necessary for children identified or suspected of having language difficulties. CHEO provides services to children with speech disorders and the School Board is responsible for language development.
- ☐ If the referral is for voice therapy, an Ear, Nose and Throat (ENT) Physician's referral is necessary. Please attach ENT's assessment report (within 6 months of the referral date).
- ☐ CHEO services children with articulation disorders at or beyond the moderate level of severity. The School Board is responsible for mild articulation difficulties.
- ☐ All children referred to the CHEO School Speech Therapy Services program must be 5 years of age or older to receive service.

Mail or fax the above information to the CHEO for follow-up at:

100-4200 Labelle Street
Ottawa, Ontario. K1J 1J8
Pediatric Phone Numbers: 613-745-4358, 1-844-641-7078
FAX: 1-866-869-0071

Note:

- Completion of the above steps in the checklist is required to ensure that the application is complete and ready for processing.
- A certified Speech Language Pathologist must complete all speech language pathology referrals to CHEO.

Information about the program, as well as this form, can be found on our CHEO website.
http://www.cheo.on.ca/en/school-based-rehab

CHEO

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GENERAL INFORMATION:

D.O.B _____ Grade: _____

Date of Screening _____ Teacher _____

Referral: New ☐ Re-referral to CHEO ☐

Referring Speech-Language Pathologist _____

Presenting Problem(s) _____

Pertinent Medical History

Previous Speech Therapy: Yes ☐ No ☐

Describe _____

Language(s) Spoken at Home _____

LANGUAGE SKILLS:

- Within Normal Limits (WNL): Yes ☐ No ☐

If *no*, please complete the following:

- Date of completed Speech and Language Assessment _____

***** Note: Speech and Language Assessment/Progress/Discharge Report must be within 1 year of referral date and be attached to referral form.***

- Language Services:_____

  To be initiated: Yes ☐ No ☐ Planned Start Date _____

- Receiving SLP Therapy services:

  Direct ☐ Consultative ☐ Communication Disorders Assistant Support ☐

  No longer receiving SLP Support ☐ Discharge Date _____

- Class Placement:

  Regular/Mainstream ☐ Living/Learning ☐ Language Class ☐

  Other _____

BEHAVIOUR:

- WNL: Yes ☐ No ☐ Attention difficulties ☐
- Other _____

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Name: _____ School: _____

HEARING:

- Concerns: Yes ☐ No ☐
- History of ear infections: Yes ☐ No ☐
- Recent Hearing Test: Yes ☐ No ☐ Date
  If ***yes***, results: Loss: Right Ear ☐ Left Ear ☐ Both ☐
  Aided: Yes ☐ No ☐
- Referral made for audiological exam Yes ☐ No ☐ Date _____

FLUENCY:

- WNL: Yes ☐ No ☐
- Onset: Gradual ☐ Sudden ☐ Date _____
- Family History of Speech/Language Disorders/Dysfluency: Yes ☐ No ☐
- Level of Severity: Mild ☐ Moderate ☐ Severe ☐
- Please describe dysfluencies observed:
  _____
- Secondary Characteristics: Yes ☐ No ☐
  Describe _____
- Dysfluent in primary language Yes ☐ No ☐

ARTICULATION/PHONOLOGY:

- WNL: Yes ☐ No ☐
- Level of Severity: Mild ☐ Moderate ☐ Severe ☐ Profound ☐
- Describe Specific Errors/Processes Present: _____
  _____
  _____
- Stimulability: Yes ☐ No ☐
  Identify stimulable phonemes:
- Other comments/information: _____
  _____
- Dentition: WNL: Overbite ☐ Under bite ☐ Open bite ☐

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Name: _____ School: _____

ORAL MOTOR DIFFICULTIES:

- WNL: Yes ☐ No ☐
- Nonverbal: Yes ☐ No ☐
- Unintelligible: Word level ☐ Sentence level ☐ Conversation ☐ All levels ☐
- Spontaneously produces single sounds/syllables: Yes ☐ No ☐
  Describe sounds produced _____
- Repetition of sounds/words ***only***: Yes ☐ No ☐
- Augmentative Communication Support Used: Yes ☐ No ☐
  Describe: _____
- Difficulty with non-speech oral tasks: Yes ☐ No ☐
- Difficulty with sequencing of syllables/words: Yes ☐ No ☐
- Other Comments: _____

VOICE:

- WNL: Yes ☐ No ☐
- Referral to Ears/Nose/Throat Physician Recommended: Yes ☐ No ☐
- Scheduled Appointment Date: _____
- ENT report provided: Yes ☐ No ☐ Date of Report: _____

  *****Note: ENT report must be within 6 months of date of referral to CHEO.***

- Vocal Quality: WNL ☐ Strained ☐ Hoarse ☐ Aphonic ☐
- Other: _____
- Pitch/Intonation: WNL ☐ High ☐ Low ☐ Monotone ☐ Pitch Breaks ☐ Reduced Pitch Range ☐
- Volume: WNL ☐ Loud ☐ Soft ☐ Reduced Range ☐
- History of Vocal Abuse/Misuse: Yes ☐ No ☐ Vocal Nodules Present ☐
- Resonance: Hypernasal ☐ Hyponasal ☐ Nasal Air Emission ☐
- Comments: _____

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CLEFT PALATE:

- WNL: Yes ☐ No ☐
- If ***yes***, Repaired ☐ Unrepaired ☐ Date _____
- Prosthesis: Yes ☐ No ☐
  Describe _____
- Report Provided From Cleft Palate team: Yes ☐ No ☐
- Articulation Difficulties: Yes ☐ No ☐
- Resonance Difficulties: Yes ☐ No ☐
- Comments: _____

ADDITIONAL INFORMATION/COMMENTS _____

Speech/Language Pathologist Contact Information _____

Referral Date: _____