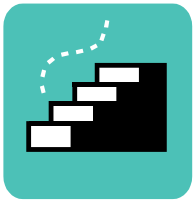
HOW TO REFER AN ELEMENTARY STUDENT FOR SPEECH AND LANGUAGE SERVICES

4 EASY STEPS



1. Parent and/or teacher jointly identify and decide if a speech and language services referral is needed.

2. School staff fill out an Individual Service Request (ISR) form.
   ISRs are available at the school or can be printed from the Capital Health Website
   www.capitalhealth.ca/schoolsandpreschools

Form	Who completes it	What next?
Individual Service Request	Principal or Designate	Fax to SHIP Central Intake

3. After the Individual Service Request (ISR) form is reviewed, it is faxed back to the school and shows the client status.
   The school gets the referral package completed as outlined below.

Form	Who completes it	What next?
• Client History – School Services Speech & Language Services	Parent / Legal Guardian	Give to teacher
• Consent – School Health Services	Parent / Legal Guardian	Give to teacher
• Teacher Checklist – Speech and Language Services	Teacher	Teacher attaches to parent forms (Client History, Parent Consent) and forwards to Principal/designate

4. The Principal or School Designate then sends the completed Speech Referral package to the Speech-Language Pathologist.

NOTE: Students cannot be seen until the <u>completed</u> referral package (including the signed consent form) is received.

Capital Health

Individual Service Request
Student Health Services

Community Health Services

Print Clearly and FAX to 413-7629

Student Name *(Last / First)* _____ D.O.B. *(Day / Month / Year)* _____

Also known as _____ ☐ Male ☐ Female

Referring School / Agency _____ Fax _____ Grade _____ Room _____

Receiving School (transition) _____ Fax _____ Grade _____

☐ Speech and Language	☐ Occupational Therapy (fine motor)	☐ Hearing Screening	☐ Dental Health
☐ Nursing	☐ Physiotherapy (gross motor)	☐ Vision Screening	☐ Mental Health

☐ Other _____

NOTE: for Sensory Multi-handicapped and Dependent Handicapped Service contact Edmonton Regional Education Consulting Services at 472-5825.

Describe the problem (concern, severity, duration, diagnosis) _____

What has been done to try to solve the problem *(Identify past / present service providers, including school consulting services)*

Referring Person _____ Position _____

Best time for contact _____ Phone _____ Fax _____

☐ I confirm the parent / guardian is aware of this referral and agrees to an initial assessment.

_____ _____ _____

(Print Name of Principal / Designate) *(Signature)* *(Date)*

OR

☐ I confirm that I have signed the parent / guardian consent for School Health Services (Capital Health).

_____ _____ _____

(Print Name of Parent / Guardian) *(Signature)* *(Date)*

Parent(s) / Guardian(s) _____ Relationship to child _____

Address _____ Postal Code _____

Phone *(Home)* _____ *(Work)* _____ *(Other)* _____

Language / Culture Interpreter required? ☐ No ☐ Yes Language / Culture / Dialect _____

To be completed by Central Intake Staff

Staff Assigned / Designation *(Print)* _____

To be completed by Student Health Services Staff

Referral Status _____

_____ Date *(d / m / y)* _____

Capital Health
Edmonton and area

Primary Care Division
Community Health Services

Dear Parent / Legal Guardian:

Your child has been referred for speech and language services. **We must receive the attached Client History & Consent form before the Speech Language Pathologist (S-LP) can see your child.**

According to the Health Information Act, Capital Health needs your **signed** consent to obtain and share information about your child with the school. Your privacy and the confidentiality of the information are protected under that act. To avoid delays please make sure that **all** sections are completed.

After we receive your signed forms the S-LP may:

- watch your child in the classroom
- review your child's school file
- do activities outside the class with your child
- talk with your child's teacher

An S-LP Assistant may help with parts of the assessment as directed by the S-LP.
Your child may miss some regular class work for this assessment. The following areas may be checked:

- hearing (headphones will be placed on your child's ears for this activity)
- pronunciation, and how well others can understand your child's speech
- mouth and oral movements (a tongue depressor may be used to see the back of your child's mouth)
- use of words and sentences to interact and express needs, ideas, and tell stories
- understanding of words, sentences and stories
- voice (pitch, loudness, quality)
- smoothness/ fluency of speech

Please return the ***SIGNED and witnessed*** Consent and Client History forms to your child's school or to the Speech Language Services office. **We cannot provide any services to your child until the S-LP receives these completed forms.**

The S-LP will contact you after the assessment to discuss the results. If you have any questions or concerns, please contact your child's teacher, or the local Health Centre to reach your School Speech & Language Services office.

Yours truly,

Speech and Language Services

Enclosures

Capital Health

Student Health Initiative Partnership
and Community Health Services

Consent

School Health Services

Name *(Last / First)* _____

D.O.B. *(Day / Month / Year)* _____ ☐ Male ☐ Female

Alberta Personal Health Number _____

School / Agency _____ Gr. __

Rm. ____ Alberta Learning Number _____

Purpose of this form - This form documents your consent to have Capital Health staff serve your child and share relevant information with other participating organizations in the Student Health Initiative Partnership (SHIP) for the purpose of providing treatment / programming to support your child's health and / or educational needs. We do so in accordance with the *Health Information Act,* ss. 34, *Freedom of Information and Protection of Privacy Act,* s. 40. SHIP is made up of health, education, social services and mental health organizations coordinating and providing health services to students.

To be signed by parent(s) / legal guardian(s) in both sections

Consent For Service

- I give permission for my child, _____ to receive health services from the Capital Health school health team members which may include:
  - ☐ Occupational Therapy (OT)
  - ☐ Physical Therapy (PT)
  - ☐ Speech-Language Services (SLS)
  - ☐ Emotional Behaviour Services
  - ☐ Home Care Services (including nursing, OT and PT)
  - ☐ Nursing Services
- I understand that I will have the results and recommendations explained to me following assessment.
- I understand that treatment / intervention will only be provided if services are required and agreed to by parent / guardian and child.
- I understand that this consent is effective upon signing and is valid until the student health services are completed. I further understand that I may revoke this consent at any time in writing.

_____ _____

Name of Parent / Guardian *(please print)* Signature of Parent / Guardian

_____ _____ _____

Date Name of Witness *(please print)* Witness Signature

Consent To Disclose Health Information

☐ I give consent for members of my child's Capital Health school health team to disclose relevant health registration, assessment, diagnostic, and treatment information to staff at my child's school and other SHIP partners.

☐ I give consent for the schools and other SHIP partners to disclose relevant health registration, assessment diagnostic, and treatment information to members of my child's Capital Health school health team.

☐ I give consent for members of my child's Capital Health school health team to disclose relevant health registration, assessment, diagnostic, and treatment information to _____ .

☐ I give consent for _____ to disclose relevant health registration, assessment, diagnostic, and treatment information to members of my child's Capital Health school health team.

I understand why I have been asked to disclose my child's health information, and am aware of the risks and benefits of consenting or refusing to consent. I further understand that I may revoke this consent at any time in writing.

_____ _____

Name of Parent / Guardian *(please print)* Signature of Parent / Guardian

_____ _____ _____

Date Name of Witness *(please print)* Witness Signature

The information on this form is disclosed under the authority of section 34 of the *Health Information Act* and is for the purpose of providing student health services. If you have questions about the collection of this information please contact the School Services Regional Manager, Plaza 124, Suite 300, 10216 - 124 Street, Edmonton, AB (780) 413-7900.

Capital Health

Community Health Services

Client History - School Services

Speech and Language Services

Name *(Last / First)* _____

D.O.B. _____ ☐ Male ☐ Female
(day / month / year)

Alberta Personal Health # _____

Address _____

Postal Code _____ Home Phone _____

(TO BE COMPLETED BY PARENT OR GUARDIAN)

Family Information

Mother *(first and last name)* _____

Home phone number _____ Work _____ Other _____

Father *(first and last name)* _____

Home phone number _____ Work _____ Other _____

Client History

What are your concerns about your child's speech and language? _____

What has been done to try to solve the problem? _____

Is there a family history of speech, language, hearing or learning problems?

☐ No ☐ Yes, explain _____

Is your child concerned with his / her speech or language difficulties?

☐ No ☐ Yes, explain _____

Were there any concerns with your child's development of sitting, walking, talking, or self-feeding?

☐ No ☐ Yes, explain _____

Does your child speak any language(s) other than English?

☐ No ☐ Yes, explain what languages and indicate the number of years and kinds of exposure to English _____

Is your child receiving any special assistance? (i.e. funding, special class placement, therapy, etc.)

☐ No ☐ Yes, explain _____

Has the child been seen by:

Yes	No		Yes	No	
☐	☐	Speech-language pathologist	☐	☐	Occupational therapist
☐	☐	Educational psychologist	☐	☐	Physical therapist
☐	☐	Reading specialist	☐	☐	Audiologist

Explain _____

The information on this form is collected under the authority of section 34 of the *Health Information Act* and is for the purpose of providing speech/language services. If you have questions about the collection of this information please contact the School Health Services Regional Manager, Plaza 124, Suite 300, 10216-124 Street, Edmonton, AB (780) 413-7900.

Please mark ☒ the items below that apply to your child.

Speech Concerns

- ☐ Difficulty saying some sounds
- ☐ Difficulty being understood by others

Language Concerns

- ☐ Difficulty understanding what you say
- ☐ Difficulty following directions
- ☐ Difficulty organizing and expressing ideas
- ☐ Difficulty communicating effectively with others
- ☐ Uses limited vocabulary
- ☐ Uses immature grammar

Voice Concerns

- ☐ Unusual pitch, volume, or quality of voice

Stuttering / Fluency Concerns

- ☐ Repeats whole words
- ☐ Repeats parts of words
- ☐ "Gets stuck" on words or sounds

Social Concerns

- ☐ Difficulty listening or paying attention
- ☐ Difficulty making / keeping friends
- ☐ Difficulty dealing with anger / frustration

Health / Other Concerns

- ☐ Hearing problems / frequent ear infections
- ☐ Behaviour problems
- ☐ Learning difficulties
- ☐ Significant health problems, e.g. allergies

describe _____

_____

Pertinent Assessment(s) and / or Intervention(s)

- ☐ Educational assessment
- ☐ Reading assessment
- ☐ Cognitive assessment
- ☐ Psychological assessment
- ☐ Other _____

_____

_____

Comments _____

_____

_____

In what way is the speech-language problem affecting your child's social / classroom functioning? _____

_____

_____

_____

_____

Is there anything else you would like us to know about your child? (special conditions, syndromes, disorders) _____

_____

_____

_____

_____

Completed by _____ Relationship to child _____ Date _____

Guidelines for Form Use

Complete these Guidelines and forward to stakeholders with the proposed form

FORM NUMBER / CREATION DATE	CHPF-0296 January 2005
FORM TITLE	Client History - School Services Speech and Language Services

PURPOSE:

- To collect relevant background information and current speech language concerns when a child is referred for school speech and language services

USERS: *(Who will fill in the form? Who will use the information?)*

- To be completed by parent / legal guardian referring a school age child for speech and language services
- To be completed by partnering agencies (eg early education programs, Head Start programs, etc) referring a child for further speech and language services through Capital Health, Community Health Services

LOCATION: *(Where will the form be filed? e.g., patient chart. If it is to be retained on the permanent patient record, state the recommended location as per the Universal Chart Order. If not, please state to whom and where the form should be forwarded. e.g. Home Care. Who is designated to receive the original or copy, who is responsible for distribution and when?)*

- To be filed in client's health record under 'Referral / Consents'

INSTRUCTIONS: *(Specific instructions on how to complete the form)*

Upon receiving an *Individual Service Request CHPF-0371* or *Request for Community Health Services CHPF-0204:*

- Have school provide the family with the *Client History Form CHPF-0296* and *Consent Form CHPF-0444* for completion
- Attach client label top right corner and forward the form to the family for completion (along with *Consent Form CHPF-0444* (rural SLP's) or *Consent CHPF-0314* (urban SLP's)

  Or

- Attach client label top right corner and send the form to the family for completion (along with the *Consent Form CHPF-0444* and the form letter *Referral Package Sent CHPF-0320)*

REPLACES:

- All previously dated versions

Capital Health

Community Health Services

Teacher Checklist

Speech and Language Services

Name _____
Last First

D.O.B. _____ ☐ Male ☐ Female

PHN _____

Please mark ☒ the items below that apply to the child.

Speech Concerns

- ☐ Difficulty saying some sounds
- ☐ Difficulty being understood by others

Language Concerns

- ☐ Difficulty understanding what you say
- ☐ Difficulty following directions
- ☐ Difficulty organizing and expressing ideas
- ☐ Difficulty communicating effectively with others
- ☐ Uses limited vocabulary
- ☐ Uses immature grammar

Voice Concerns

- ☐ Unusual pitch, volume, or quality of voice

Stuttering / Fluency Concerns

- ☐ Repeats whole words
- ☐ Repeats parts of words
- ☐ "Gets stuck" on words or sounds

Social Concerns

- ☐ Difficulty listening or paying attention
- ☐ Difficulty making / keeping friends
- ☐ Difficulty dealing with anger / frustration

Health / Other Concerns

- ☐ Hearing problems / frequent ear infections
- ☐ Behaviour problems
- ☐ Learning difficulties
- ☐ Significant health problems

Pertinent Assessments and / or Intervention

- ☐ Educational assessments
- ☐ Reading assessments
- ☐ Cognitive assessments
- ☐ Psychology assessments
- ☐ Other _____

Comments _____

In what way is the speech-language problem affecting the child's social / classroom functioning? _____

Is there anything else you would like us to know about the child? (special conditions, syndromes, disorders) _____

Completed by _____ Date _____

School _____ Grade _____ Room # _____

Guidelines for Form Use

Complete these Guidelines and forward to stakeholders with the proposed form

FORM NUMBER / CREATION DATE	CHPF-0295 November 2005
FORM TITLE	Teacher Checklist Speech and Language Services

PURPOSE:

- To document student's speech and language concerns in the classroom

USERS: *(Who will fill in the form? Who will use the information?)*

- Teachers
- Speech-Language Pathologists

LOCATION: *(Where will the form be filed? e.g., patient chart. If it is to be retained on the permanent patient record, state the recommended location as per the Universal Chart Order. If not, please state to whom and where the form should be forwarded. e.g. Home Care. Who is designated to receive the original or copy, who is responsible for distribution and when?)*

- To be filed in the student's speech and language file under 'Referral / Consent'

INSTRUCTIONS: *(Specific instructions on how to complete the form)*

- Prior to providing the teacher with the checklist, the S-LP explains how to use the form
- Once form is completed, the S-LP reviews it, makes a plan and shares it will all relevant parties

REPLACES:

- This form replaces all previous hard copy (paper) forms serving the same function