Department of Education

SPEECH PATHOLOGY REFERRAL REPORT
LANGUAGE DEVELOPMENT CENTRE PLACEMENT
KINDERGARTEN 2022

STUDENT DATA

NAME:_____ **DOB:**_____ **GENDER**: ☐Male ☐Female

CHRONOLOGICAL AGE AT TIME OF ASSESSMENT: _____ **POST CODE:**_____

IS THIS CHILD AN AUSTRALIAN CITIZEN OR PERMANENT RESIDENT: ☐Yes ☐No

NB: If the applicant is not an Australian Citizen/Permanent Resident you must contact TIWA on 9218 2100 to discuss eligibility for LDC enrolment prior to submitting the referral

DOES THIS CHILD COME FROM A CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUND?

☐Yes → Please Complete the Questionnaire in Appendix 1 ☐No → Do not complete Appendix 1

IS THIS CHILD OF ABORIGINAL OR TORRES STRAIT ISLANDER BACKGROUND?

☐Yes ☐No

IS THIS CHILD UP TO DATE WITH THEIR IMMUNISATIONS, ON AN APPROVED CATCH-UP SCHEDULE, OR HAVE A MEDICAL EXEMPTION? ☐Yes ☐No

HOME ADDRESS:_____

DAY CARE:_____

MONTH AND YEAR OF FIRST EVER S.P. CONTACT: _____

PREVIOUS THERAPY: ☐None – assessment only ☐Minimal contact/Indirect contact ☐Regular intervention

WHO HAS INITIATED THE REFERRAL? ☐Parent ☐Speech Pathologist ☐Other_____

REFERRER INFORMATION

REFERRING SPEECH PATHOLOGIST:

Name: _____

Organisation:_____

Address: _____

_____

Post Code: _____ Phone:_____

Email:_____

PAEDIATRICIAN/ MEDICAL OFFICER /PSYCHOLOGIST:

Name:_____

Organisation:_____

Address:_____

_____

Post Code: _____ Phone:_____

Email: _____

PARENT/CARER INFORMATION

MOTHER/CARER 1:_____ **FATHER/CARER 2:**_____

PHONE NUMBER: _____ PHONE NUMBER: _____

EMAIL: _____ EMAIL: _____

CASE WORKER (if applicable):_____

PARENT/CARER CONSENT

I have read the above details and declare them to be true and correct. I wish this application for placement at the _____ Language Development Centre to be considered. I understand that the referral does not guarantee placement. I am prepared to support and assist with my child's educational program should she/he be accepted.

Signed: _____ **Date:** _____

ADDITIONAL SERVICES

DOES THE CHILD HAVE:

An intellectual disability?

☐Yes ☐No

Severe epilepsy?

☐Yes ☐No

Autism or Asperger's Syndrome?

☐Yes ☐No

Global Developmental Delay?

☐Yes ☐No

OTHER AGENCIES INVOLVED (if known):

☐Paediatrician / Medical Officer

Contact Name:_____ Phone Number:_____

☐ Developmental assessment completed and copy attached

☐Occupational Therapist

Contact Name:_____ Phone Number:_____

☐Physiotherapist

Contact Name:_____ Phone Number:_____

☐Disability Services Commission (DSC)

Contact Name:_____ Phone Number:_____

☐National Disability Insurance Agency (NDIA)

Contact Name:_____ Phone Number:_____

☐Autism Association

Contact Name:_____ Phone Number:_____

☐The Ability Centre (formerly Centre for Cerebral Palsy)

Contact Name:_____ Phone Number:_____

☐School of Special Educational Needs Sensory (SSENS)

Contact Name:_____ Phone Number:_____

☐Other(s)

Contact Name:_____ Phone Number:_____

TRANSPORT REQUIREMENTS

- This information is to help inform school planning only.
- Transport information provided does not define or limit families' transport options upon enrolment.
- Please note that students attending full time LDC placements (i.e. Pre-primary, Years One and Year Two students) are prioritised for seats on the bus over those attending part-time placements (i.e. Kindergarten students).

☐Education Department transport (school bus service) is required because access to other transport is limited.

☐Education Department transport (school bus service) is preferable, but not essential.

☐No Education Department transport is required.

CASE HISTORY

Please note: Your own case history form or a case history within your assessment report may be attached **as long as the following details are addressed within the form and the information is current**:

FAMILY DETAILS (eg current family status, custody/guardianship, living arrangements, siblings).

PARENT'S/CARER'S ATTITUDE TO REFERRAL: ☐Eager ☐Supportive ☐Accepting ☐Indifferent ☐Hesitant

FAMILY HISTORY OF SPEECH, LANGUAGE, LEARNING DIFFICULTY AND/OR DEVELOPMENTAL DELAY

RELEVANT MEDICAL & CASE HISTORY
Birth History

Did/does your child have difficulty with feeding or eating? (suckling, gagging, reflux, difficulty with solids, limited foods)

Speech and Language Development/milestones

Did your child make lots of cooing and babbling sounds ("ba-ba", "ga-ga") before learning to talk? ☐Yes ☐No

First words at: ☐9-18mt ☐18mt-2yrs ☐2-3yrs ☐after 3yrs ☐Not yet

Word Combinations at: ☐18mt-2yrs ☐2-2;6yrs ☐2;6-3yrs ☐3-4yrs ☐Not yet

Other comments:

Hearing (eg date last assessed, results, history of middle ear infection, grommets etc)

Motor Development/milestones (gross and fine motor)

Sat _____ Crawled _____ Walked _____

Other comments: _____

Vision (eg date last assessed, results)

Medical Conditions, Operations etc

Is your child toilet trained during the day? ☐Yes ☐No

Other Comments_____

CELF-PRESCHOOL 2

Please complete all relevant subtests in order to obtain receptive and expressive language scores.
****Please attach the raw data.***

D.O.A.:____/___/_____ **Age at Ax: ____;_____**	**R.S.**	**S.S.**	**Percentile Rank**
Sentence Structure			
Word Structure			
Expressive Vocabulary			
Concepts and Following Directions			
Recalling Sentences			
Basic Concepts			
Word Classes – Receptive			
Word Classes - Expressive			
CORE LANGUAGE SCORE			
RECEPTIVE LANGUAGE SCORE			
EXPRESSIVE LANGUAGE SCORE			

Please add any relevant comments about student performance and/or behaviour during the CELF P2

Physical Activity ☐Appropriate ☐Very active ☐Passive

Attention to Task ☐Most of the time ☐required some breaks and redirection ☐required frequent breaks and redirection

Response Rate ☐Appropriate ☐Too fast ☐Delayed

RENFREW ACTION PICTURE TEST

<u>This is a compulsory component of the referral</u>

Please provide the child's responses to the stimulus pictures in the Renfrew Action Picture Test (RAPT)

**Scoring of this test is optional.*

Information Score	**Mean for age OR Percentile Rank**	**Grammar Score**	**Mean for age OR Percentile Rank**

SPEECH

Does the child present with: ☐CAS ☐Phonological disorder ☐Delayed phonology

Please rate both severity and intelligibility

Severity rating:	**AND**	**Intelligibility rating:**
☐ Severe		☐ Mostly unintelligible
☐ Moderate		☐ Mostly intelligible at 1-2 word level if context is known
☐ Mild		☐ Mostly intelligible at discourse level if context is known
☐ Age appropriate/resolving		☐ Intelligible at discourse level whether or not context is known

Please comment on phonological processes if evident (attach any raw data or speech reports if available)

Was accessing speech pathology services a priority for the family/carers? ☐Yes ☐No
If yes, please list intervention focus and comment on degree of improvement:

Has the child used an alternative or augmentative communication system?
☐Yes currently ☐Yes previously ☐No

Please specify communication system and provide details: _____

PRAGMATIC AND ADDITIONAL INFORMATION

Does the child have difficulty with joint attention?
☐Yes ☐Variable ☐No

Does the child have difficulty maintaining appropriate eye contact?
☐Yes ☐Variable ☐No

Does the child have flat affect or display a mismatch between words/feelings and facial expression?
☐Yes ☐Variable ☐No

Is the child's play repetitive or rote?
☐Yes ☐Variable ☐No

Does the child display word finding difficulties?
☐Yes ☐Variable ☐No

Does the child use jargon?
☐Yes ☐Variable ☐No

The child's communication style is:
☐Passive ☐Active ☐Dominating ☐Non-communicative ☐Other_____

If the child's conversation is restricted to a particular topic? ☐ Yes ☐Sometimes ☐No
If yes, please state the topic:_____

Is the child aware of comprehension breakdown?
☐Yes ☐Variable ☐No

If yes, what strategies are evident? ☐Requests for repetition ☐Non-verbal signs ☐Other

If possible, please comment on the child's attention and social skills:

LANGUAGE SAMPLE:

For some children with language impairment standardised assessment measures alone are not sufficient in representing their difficulties in a conversational language context. In cases when a child's functional language performance is lower than their language indexes on the CELF-P2 or when a child performs exceptionally low on the CELF, it is recommended that referring clinicians provide a **representative language sample** to assist us in processing the referral.

Please provide a representative language sample that follows the child's lead and reflects the child's typical performance.

- The language sample should contain a **minimum of 25** of the child's utterances.
- **Please record BOTH the child's and the conversational partner's utterances.**
- Make note of any non-verbals such as gestures and any contextual support provided.
- If the child is largely non-verbal please make comments regarding their communicative intent.

**A video or audio recording of the interaction can be submitted in lieu of a transcription.*

Context: _____

FLUENCY AND VOICE

Does the child have a history of stuttering or voice issues?

☐Yes ☐No

If yes, please comment

THERAPY TO DATE

	Number of sessions	Number of blocks	Goals of Therapy
Individual			
Group			
Other			

Therapy attendance: ☐regular ☐inconsistent ☐poor **Progress:** ☐good ☐moderate ☐limited

Please comment about the child's progress in therapy:

SUMMARY AND ADDITIONAL COMMENTS

The summary may include brief information regarding:

- whether the child's language difficulties are within the receptive and/or expressive domain, and whether the applicant presents with additional speech and/or fluency difficulties;
- the severity of the child's language and/or speech disorder (e.g. severe, moderate, mild);
- the child's strengths and weaknesses in different language areas (e.g. comprehension, semantics, syntax, narrative, phonological awareness or pragmatics); and
- the impact of the child's language difficulties in the home or educational environment (e.g. peer interactions, ability to access the curriculum).

Clinician signature: **Date:**