



SPEECH PATHOLOGY REFERRAL REPORT
LANGUAGE DEVELOPMENT CENTRE/SCHOOL PLACEMENT
KINDERGARTEN 2025

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: _____ ECEC: _____

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/School 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: _____

Please complete all relevant subtests in order to obtain receptive and expressive language scores. Please attach raw data. You may attach the scored raw data in lieu of filling out this table.

Raw data with scoring is attached.

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

Please add any relevant comments about student performance and/or behaviour during the CELF P3

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

This is a compulsory component of the referral

Please provide the child's responses to the stimulus pictures in the Renfrew Action Picture Test (RAPT) or attach the raw data.

Raw data for the RAPT is attached.

**Scoring of this test is optional.*

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

Does the child present with: CAS Phonological disorder Delayed phonology

Please rate both severity and intelligibility at the time of LDC referral

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)

Speech data is attached.

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

Which one describes the child's usual use of eye contact?

Well matched to the context Fleeting Directed away from the conversational partner

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 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:

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 of the interaction can be submitted in lieu of a transcription.*

In cases when a child's functional language performance is lower than their language indexes on the CELF-P3 or when a child's performance on the CELF-P3 exceptionally low but their functional skills are comparatively stronger, it is recommended that referring clinicians provide a **representative language sample video** to assist us in processing the referral.

A video of an interaction is attached.

Context: _____

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

No Yes *Please comment*

THERAPY TO DATE

Please comment on how much therapy the child has received.

E.g. **“Fortnightly 45 minute individual sessions for the last three months focussing on sentence structures.”**

**You don't need to provide the exact number of sessions or precise therapy goals.*

Therapy attendance: regular inconsistent poor Progress: good moderate limited

Please comment about the child's progress in therapy:

ADDITIONAL COMMENTS

Please provide us with your clinical impressions of the child particularly, their functional language skills.

Clinician signature: _____ Date: _____