Department of Education
GOVERNMENT OF WESTERN AUSTRALIA

SPEECH PATHOLOGY REFERRAL REPORT
LANGUAGE DEVELOPMENT CENTRE/SCHOOL PLACEMENT
KINDERGARTEN 2026

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 CALD Questionnaire* ☐No → *Do not complete CALD Questionnaire*

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 Select 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:**_____

REFERRAL REQUIREMENTS CHECKLIST

The person responsible for completing the documents must also ensure they are sent to the LDC.

SPEECH PATHOLOGIST TO COMPLETE:

- ☐ **2026 LDC Speech Pathology Referral Report KINDY** and all associated assessments.
- ☐ **2026 LDC Case History Form** or alternative case history form (essential)
- ☐ **ASQ Ages and Stages Questionnaire** (strongly recommended in the absence of a paediatrician report) please ensure it is fully scored, and the raw data is included.
- ☐ **2026 LDC Parent-Carer Questionnaire KINDY** completed by the child's parent/carer.
- ☐ **2026 LDC Parent-Carer Questionnaire KINDY** if the child attends a daycare or ECEC, the child's educator is to complete a questionnaire as well.
- ☐ **2026 CALD Questionnaire** completed by a speech pathologist and the child's parent/carer if the child has a culturally and linguistically diverse background. *If a family identifies as Aboriginal or Torres Strait Islander, this form does not need to be completed unless English or Aboriginal English is not the primary language.*
- ☐ **Raw CELF-P3 form and additional raw data.**
- ☐ **Video** (optional but highly recommended). If possible, please provide a short video to support the referral. Guidelines for the video:
    - Recommended length: 2 to 5 minutes
    - Should capture play or conversational interaction between the child and a clinician or caregiver
    - Both the child and the interaction partner should be visible in the frame for most of the video.

PAEDIATRICIAN/MEDICAL OFFICER TO COMPLETE:

- ☐ **A Developmental Assessment** (is highly recommended, but not mandatory). A Griffith's Assessment administered by a paediatrician or medical officer is a suitable assessment.

**Children being referred for kindergarten must have up-to-date immunisation records or be on an approved catch-up schedule or have a medical exemption.*

DUE DATES

Referrals for Kindergarten: Wednesday 24th September 2025 (Term 3, Week 10)

CASE HISTORY FORM

Please note: A comprehensive case history is a vital part of the referral. Please ensure a completed case history form is included with this referral to support the intake and assessment process.

☐ The LDC case history form is attached. ☐ An alternative case history form is attached.

ADDITIONAL SERVICES

DOES THE CHILD HAVE:

Epilepsy?

☐No ☐Yes _____

Diabetes?

☐No ☐Yes _____

Severe Allergies?

☐No ☐Yes _____

Formal Diagnosis of Global Developmental Delay?

☐No ☐Yes _____

If Yes, please attach a copy of the formal diagnosis report.

☐ GDD diagnosis report attached

Is the child currently on a waitlist / undergoing assessment for any of the following? ☐ASD ☐GDD ☐ADHD

OTHER AGENCIES INVOLVED

☐Paediatrician / Medical Officer

Contact Name:_____ Phone Number:_____

Reason for seeing Paediatrician/Medical Officer:_____

☐ Developmental assessment completed and copy attached.

☐Occupational Therapist

Contact Name:_____ Phone Number:_____

☐Physiotherapist

Contact Name:_____ Phone Number:_____

☐National Disability Insurance Agency (NDIA/NDIS)

Contact Name:_____ Phone Number:_____

☐School of Special Educational Needs Sensory (SSENS)

Contact Name:_____ Phone Number:_____

☐Department of Communities

Contact Name:_____ Phone Number:_____

☐Other Agencies Involved:

Agency Name_____

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 and Years One 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.

CELF-PRESCHOOL 3

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

☐Raw data with scoring is attached.

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

<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) 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**

SPEECH

Does the child present with:

☐ Delayed phonology ☐ Phonological disorder ☐ CAS *(If ticked, please attach a formal diagnosis report)*

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: _____

PRAGMATICS 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 **Optional*

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

A representative language sample is strongly recommended when:

- The child's functional language skills appear lower than their CELF-P3 language index scores.
- The child's CELF-P3 scores are exceptionally low, but their functional communication is comparatively stronger.

Language sample transcript guidelines:

- Include **at least 25** of the child's utterances.
- Record **both** the child's and the conversational partner's utterances.
- Note **non-verbal communication** (e.g., gestures) and any **contextual support** provided.
- If the child is mainly non-verbal or unintelligible, include observations about their **communicative intent**.

A video of the interaction can be submitted in lieu of a transcription.

Video guidelines:

- Recommended length: **2 - 5 minutes**
- Should capture **play or conversational interaction** between the child and a clinician or caregiver
- Both the child and the interaction partner should be visible in the frame for most of the video

☐ **Language sample transcript attached.**

☐ **Video is attached.**

Context:_____

FLUENCY AND VOICE

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.

For example, **"**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:

PARENT/CARER PERSPECTIVE ON REFERRAL

Please indicate the parent's/carer's attitude toward the referral:

☐ Eager ☐ Supportive ☐ Indifferent ☐ Uncertain ☐ Anxious

CLINICAL OPINION

Please provide your clinical impressions of the child you are referring. *This information is a critical aspect of the referral and supports our understanding of the child's communication across standardised assessment, intervention and informal interactions (use of functional language). This should include your clinical judgement regarding the degree to which the child meets the criteria for primary language disorder. You do not need to reiterate information already provided in other areas of the referral; however additional clinical thinking is important.*

Clinician signature: _____ **Date:** _____