Henry-Stark Counties Special Education District #801
1318 W. Sixth Street, P.O. Box 597- Kewanee, IL 61443-0597
Telephone: (309) 852-5696 Fax: (309) 853-4398

Speech Referral Form

Student name: _____ DOB: _____
First Middle Last

Parent name (Mother) _____

Parent name (Father) _____

Language spoken by child: _____Language spoken at home: _____

Teacher making referral: _____ Grade: _____

Detail your concerns with the student's speech and language skills:

Describe the adverse effect of the speech and language concern on the student's ability to learn and function in your classroom:

What other support services is the student currently receiving? (RTI, Title I, ELL, tutoring)

(turn over)

What classroom intervention strategies have been tried with this student?

Are there any medical diagnoses for this student that you are aware of? Please list. _____

_____

Is the student taking any medication that you are aware of? Please list. _____

_____

Does the student view your concern as a problem? _____

Does the parent view your concern as a problem? _____

Hearing screening date: _____ Pass/Fail
Vision screening date: _____ Pass/Fail

Other pertinent information: _____

_____

_____

Referral Request Statement

Incomplete forms will be returned to the teacher/person making referral.
The Speech/Language Pathologist will review the concerns/reasons for referral and intervention strategies used and determine whether a screening and/or evaluation is warranted according to state (ISBE) and national (ASHA) guidelines. The Speech/Language Pathologist may consult with the building principal before proceeding with an evaluation.

Person completing form: _____ Date: _____

Title of person completing form: _____

Email of person completing form: _____