

**Suwannee County School District
Office of Student Services**

Meeting Summary Sheet

Meeting Date: _____

Student Name	Grade	DOB	School Name

Notes:

Summary:

Team Recommendations:

Yes No

- Continue current interventions**
- Implement additional interventions**
- Refer for further evaluation**

Team Member Signatures

Position/Role

**Suwannee County School District
Office of Student Services
Speech Referral Form**

School: _____ **Room:** _____

Teacher: _____ **Date:** _____

Grade: _____

Student's Full Name: _____

Birthdate: _____

Description of suspected problems:

Other pertinent data:

Is this student enrolled in any special class? Yes No

Does he/she have a history of health problems? Yes No

Does he/she have a record of hearing problems? Yes No

Has he/she had previous therapy? Yes No

Teacher Signature

Parent Signature

Other

Educational Relevance of the Communication Disorder

Name of Student

Does / does not demonstrate a communication disorder that does/does not negatively impact his/her ability to benefit from the educational process in one or more of the following areas:

Academic – ability to benefit from the curriculum

Social – ability to interact with peers and adults

Academic Impact	Social Impact
List academic areas impacted by communication problems: <hr style="border: 1px solid black;"/> <hr style="border: 1px solid black;"/> <hr style="border: 1px solid black;"/> <input type="checkbox"/> Below average grades <input type="checkbox"/> Inability to complete language-based activities vs. non-language based activities <input type="checkbox"/> Inability to understand oral directions <input type="checkbox"/> Grades below the student's ability level <input type="checkbox"/> Other	List social areas impacted by communication problems: <hr style="border: 1px solid black;"/> <hr style="border: 1px solid black;"/> <hr style="border: 1px solid black;"/> <input type="checkbox"/> Peers tease student about communication problem <input type="checkbox"/> Student demonstrates embarrassment and/or frustration regarding communication problem <input type="checkbox"/> Student demonstrates difficulty interpreting communication intent <input type="checkbox"/> Other

 Speech-Language Pathologist

 LEA (Designee)

 Other Professional

 Other Professional

 Parent

 Date

Teacher Checklist - SPEECH

Student Name	Grade	DOB	School Name

Teacher name: _____

Please return completed form to: _____

Do you think the student has problems pronouncing speech sound? Yes No If YES, complete the SPEECH SOUND section below.

SPEECH SOUND (Check all that apply):

- The student uses gestures to help others understand what he/she is saying
- The student is easily frustrated when speaking
- The student is not easy to understand when the subject or context is unknown
- When the student speaks, the listener is more focused on the pronunciation than the message
- The student does not volunteer to speak in class
- The student has expressed concern about his/her speech, or about comments from peers
- The student's speech errors have an adverse effect on his/her functioning and/or performance in the

classroom, **if checked,**

Explain: _____

Do you think the child has a stuttering problem? Yes No If yes, complete the FLUENCY section below.

FLUENCY (Check all that apply):

- The student stutters when he/she speaks in the classroom
- The student demonstrates physical characteristics of frustration when speaking
- The student avoids speaking in class and other school settings
- The student has expressed concern about his/her speech, or about comments from peers
- The student's dysfluencies have an adverse effect on his/her functioning and/or performance in the classroom,

if checked,

Explain: _____

Do you think the student has a problem with his/her voice? Yes No If YES, complete the VOICE section below.

VOICE (Check all that apply):

- The student's voice quality (hoarse, harsh, breathy, or nasal) is noticeable and distracting to others
- The student's voice quality has been a concern over a period of time
- The student's hoarseness gets worse during the school day
- The student has expressed a concern about his/her speech, or about comments from peers
- The student's voice quality has an adverse effect on his/her functioning and/or performance in the classroom,

if checked,

Explain: _____

Has the parent/guardian been informed of your concern(s)? Yes No

Additional

Comments: _____

Teacher Signature: _____ Date: _____

Suwannee County School District Observations

(Observations *must* be conducted during the time when the student's learning or behavioral areas of concern occur)

Observation Date: _____

Student Name	Grade	DOB	School Name

OBSERVATION SUMMARY: Pre-intervention Observation Post-intervention Observation

Observer / Position: _____ Start Time: _____ End Time: _____

Subject Area: _____

Class Activity: Teacher directed whole class Teacher directed small group Independent work session
 Other (describe) _____

Directions: Place a (X) beside the problem behaviors that were observed *during this observation*.

	Academic Engagement	Attention / Organization	Social / Behavior
	Difficulty beginning / Completing tasks	Does not follow classroom rules	Needs constant reassurance
	Gives up easily	Does not comply to teacher direction	Cries/pouts/ sulks
	Reverse / confuses letters, words, numbers	Talks out excessively	Acts frightened; timid/shy
	Does not turn in assignments	Disorganized desk and work materials	Withdrawn
	Requires teacher prompting to work	Difficulty transitioning between tasks	Avoided or rejected by peers
	Excessively seeks others' assistance	Short attention span	Clings to teachers or others
	Does not ask for assistance	Fidgets with objects	Nervous/excitable
	Does not participate in discussion / activity	Stares blankly/seemingly daydreams	Argumentative
	Out of seat or assigned work area	Acts impulsively	Loses temper
	Language Articulation	Physical Concerns	
			Picks on others
	Difficulty understanding written directions	Seems tired / lethargic	Swears / uses profanity
	Difficulty understanding oral directions	Makes physical complaints	Changes mood rapidly
	Difficulty understanding student's speech	Poor fine motor coordination	Talks disrespectfully to others
	Difficulty answering questions verbally	Poor gross motor coordination	Damages property
	Poor use of grammar / vocabulary	Fidgets / squirms	Disrupts activities / learning environment

Narrative of observation:

Suwannee County School District

**Sensory Screening Form
Speech Only Referrals**

Student Name	Grade	DOB	School Name

Referred By: _____

Teacher: _____

Parent Consent: _____ Date: _____

HEARING	VISION
Passed <input type="checkbox"/> Failed <input type="checkbox"/>	Passed <input type="checkbox"/> Failed <input type="checkbox"/>
Comments: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	Comments: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
Person Responsible/Position Further Evaluation Required: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Evaluation: _____	Person Responsible/Position Further Evaluation Required: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Evaluation: _____