



Request for Speech-Language Consultation

Student Name _____ D.O.B. _____ School _____ Date _____

Teacher _____ Grade _____ Current IEP Yes No

Parent Name(s) _____ Primary Language _____

Address _____ Interpreter Needed Yes No

Phone Number(s) _____

Email Address _____

Date Parents Contacted by Teacher _____ Parent's Preferred Contact Method _____

Parental Concerns:

Communication Area of Concern (Check those that apply)

Speech Sound Disorders (e.g., difficulty saying sounds correctly)

1. List sounds student has difficulty saying correctly: _____
2. Do the student's speech sound errors interfere with others' understanding? Yes No
3. Share an example of how the concern interferes with participation:

Language (e.g., difficulty understanding language, putting words together to share a meaningful message, using language in a socially appropriate way and/or limited vocabulary)

1. Does the student's language difficulty interfere with his/her performance in the classroom? Yes No
2. Share an example of how the concern interferes with participation:

Stuttering (e.g., speech flow is interrupted by abnormal stopping, repetitions (st-st-stuttering) or prolonging sounds (sssstuttering))

1. Does the student's stuttering interfere with his/her performance in the classroom? Yes No
2. Share an example of how the concern interferes with participation:

Voice (e.g., problems with pitch, volume or quality of voice that distracts listeners from what is being said)

1. Does the student's voice problem interfere with his/her performance in the classroom? Yes No
2. Share an example of how the concern interferes with participation:

For the area(s) of concern checked above:

What strategies have you tried? (e.g., modeling/prompting/cuing target sounds; correct sentence structure; slow, easy speech; use of visual organizers, etc.) and results:

Best method/time for SLP to contact teacher:

Best time to observe student when he/she is displaying communication concerns:



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Speech-Language Pathologist ONLY

Date Form Received from Teacher _____

Date of Hearing Screening _____ Results _____

Date of Vision Screening _____ Results _____

Results:

Date Communicated to Parents _____ Date Communicated to Teachers _____

Screen Only _____ Occasional/Incidental _____ Gen Ed Intervention _____

Suspected Disability _____ Meeting Date _____ Outcome Evaluation No Evaluation

Results of Evaluation Entitled Not Entitled

Suggested Interventions/Comments: