SURREY PLACE
2 Surrey Place, Toronto ON M5S 2C2
T: 416-925-5141 / F: 416-925-3402
www.surreyplace.ca

Children & Youth Program

SLP REFERRAL FORM

Submit this form through confidential fax – **416 925 3402** or email - **childrens.registration@surreyplace.ca** (password protect)

Client Name:	Referring SLP:	Referral Date:
DOB:	Clinician Contact #:	
SPID# (if known):	Language(s):	

REASON FOR REFERRAL

Select all that apply and complete applicable sections of the referral form:

☐ Verbal Language (page 2)	☐ Face-to-Face AAC (page 3)
☐ Literacy (page 4)	☐ Feeding & Swallowing (page 5)

MEDIATOR MODEL (Parent Coaching) The SLP will provide an assessment and will teach the mediator to use strategies to support the client's communication at home. Please note that this is not direct 1:1 therapy with the client.

Parent/Caregiver Contact Information - *Please indicate who will be the mediator during this service.*

Obtained parent/caregiver consent for this referral to S-LP services? ☐ Yes ■ No

Parent/caregiver understands that service is provided by a mediator model, not direct therapy? ☐ Yes ■ No

Parent/Caregiver Name:	
Relationship to client:	Phone number(s):
Parent/Caregiver Address:	

DIAGNOSES

The client must have a diagnosis of Intellectual Disability (ID)

☐ Yes, the client has a diagnosis of ID	☐ No, the client does not have a diagnosis of ID

Please specify all confirmed diagnoses:

The client must be registered with Developmental Services Ontario if 16 years or older

☐ Yes, the client is registered with DSO	☐ No, the client is not registered with DSO

Current/Previous S-LP services:

Has a recent assessment/consultation been completed? ☐ Yes ☐ No

Nature of services (Please attach report(s) with referral):

VERBAL LANGUAGE

We offer assessment (standardized and/or non-standardized) and caregiver coaching to support the development of verbal language skills at home.

Client communicates using:

☐ Facial Expression	☐ Vocalizations	☐ Gestures	☐ Signs
☐ Objects	☐ Picture-Based AAC	☐ Text	☐ Echolalia
☐ Speech/Words	# of words	☐ Phrases/Sentences	% Intelligibility

Client is able to:

Demonstrate intentional communication	☐ Yes ☐ No
Independently initiate communication	☐ Yes ☐ No

Client communicates to:

☐ Request ☐ Comment ☐ Refuse ☐ Direct others ☐ Question ☐ Interact

Receptive Language Skills (please comment)

Expressive Language & Social Skills (please comment)

Current goals & strategies used at school (please comment)

Please provide details on the reason for the referral e.g. What are the priorities for communication? What are challenges? What specific goals does the parent/caregiver hope to work on?

AUGMENTATIVE & ALTERNATIVE COMMUNICATION

We offer **two** levels of AAC support: Children & Youth SLPs support *emerging* AAC users while the ACWA Program is for those using more symbolic language. Please check the eligibility criteria below to complete the correct form.

Children & Youth SLP	ACWA Program – please complete ACWA referral form!
☐ Uses fewer than 20 symbols (pictures, signs, spoken words)	☐ Uses at least 20 symbols (pictures, signs, spoken words or approximations) or can use text to communicate
☐ Does not combine symbols to make phrases	☐ Combine two or more symbols to make a phrase or sentence

Client communicates using:

☐ Facial Expression ☐ Vocalizations ☐ Gestures ☐ Signs

☐ Objects ☐ Photographs ☐ Picture Communication Symbols ☐ PECS - Level

☐ Communication Book ☐ Speech-Generating Device- specify ☐ Speech/Words

Client is able to:	
Demonstrate cause & effect skills/awareness	☐ Yes ☐ No
Demonstrate intentional communication	☐ Yes ☐ No
Independently initiate communication	☐ Yes ☐ No

If using pictures, client is able to make a choice from an array of:

☐ 2 symbols ☐ 3-5 symbols ☐ 6-10 symbols ☐ More than 10 symbols

Client communicates to:

☐ Request ☐ Comment ☐ Refuse ☐ Direct others ☐ Question ☐ Interact

Comments & examples of current communication

Environments where AAC system is being used:

☐ Home ☐ School ☐ Therapy Programs ☐ Community

Please provide details on the reason for the referral e.g. What are the priorities for communication? What are challenges? What specific goals does the parent/caregiver hope to work on?

LITERACY

Please note that this is a home-based consultative support, not school or tutoring support. Referrals for fine motor assessment for writing or typing should be directed to Occupational Therapy.

Print Motivation & Awareness	
Enjoys reading and/or writing	☐ Yes ☐ No
Initiates reading or writing	☐ Yes ☐ No
Understands what print is (e.g. text vs. pictures)	☐ Yes ☐ No

Phonological Awareness			
Syllables	☐ Demonstrates Awareness	☐ Segments	☐ Blends
Onset-Rime	☐ Demonstrates Awareness	☐ Segments	☐ Blends
Final Sound	☐ Demonstrates Awareness	☐ Segments	☐ Blends
Medial sounds	☐ Demonstrates Awareness	☐ Segments	☐ Blends
More complex words (e.g. clusters, multi-syllabic)	☐ Demonstrates Awareness	☐ Segments	☐ Blends

Alphabet & Letter-Sound Knowledge

☐ recites rote alphabet ☐ knows some letter names ☐ knows all letter names ☐ both upper- and lower-case

☐ knows letter-sounds ☐ sounds out words (or attempts) ☐ spells words based on sound (or attempts)

Client is reading (select all that apply)

☐ single words (phonics) ☐ sight words ☐ sentences ☐ longer passages

Client is writing (select all that apply)

☐ single words (phonics) ☐ sight words ☐ sentences ☐ longer passages

Current school literacy programming (please comment)

Please provide details on the reason for the referral e.g. What are priorities? What are challenges? What specific goals does the parent/caregiver hope to work on?

FEEDING & SWALLOWING

Please note that this is a home-based consultative service and **does not include instrumental assessment** of swallow function. Clients with acute respiratory needs or concern for aspiration are not appropriate for referral.

Previous or current services	
Has this client been assessed previously? Please attach any reports.	☐ Yes ☐ No
Are other professionals involved to support feeding or nutrition?	☐ Yes ☐ No
Please specify other service providers:	

Areas of concern for SLP assessment (select all that apply)			
☐ Coughing	☐ Choking	☐ Food/drink spillage	☐ Chewing skills
☐ Mealtime fatigue	☐ Meal length	☐ Food/drink texture	
Please comment:			

Related areas of concern (may require referral to another professional)			
☐ picky eating	☐ self-feeding skills	☐ nutritional status	☐ mealtime behaviours
Please comment:			

Provide details on the reason for the referral e.g. What is the priority? What does parent/caregiver hope to work on?

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