



## **INTERMEDIATE UNIT 1**

### **Department Of Communication Disorders And Sensory Impairments**

**Guidelines For Case Selection,  
Continuance And Dismissal For  
Speech/Language Services  
Within Intermediate Unit 1**

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# **PREFACE**

## **MISSION STATEMENT**

The mission of the Communication Disorders Program in Intermediate Unit 1 is to assist students to communicate effectively, so they may become confident, responsible, and independent adults in a communicative society.

## **ENDORSEMENT**

Intermediate Unit I endorses the utilization of an effective and efficient program of Speech/Language Support services to the participating public and nonpublic schools within the school districts of Fayette, Greene and Washington counties. This allows Speech-Language Pathologists flexibility in accomplishing these tasks within the framework of local operational policies.

All public school programs are in compliance with federal mandates and state standards. They also adhere to the goal of quality programming for students using best professional practices. Therefore, the following sections contain an explanation of components that are guidelines for case selection, continuance and dismissal. Case selection should be developed by speech-language pathologists through a combination of screening results and teacher referrals, followed by evaluations and multi-disciplinary team decisions. This process of evaluation and multi-disciplinary team review is also the foundation of caseload continuance and dismissal decisions.

Participating nonpublic school speech and language programs are also provided in accordance with state laws and regulations by Act 89 medical services within the IU1 area. Similar to special education services in public schools, these Act 89 services are delivered in a planned and integrated manner, which is consistent with these guidelines. These guidelines will be applied in order to provide appropriate, consistent, fiscally responsible, and quality speech-language services to the students of Fayette, Greene, Washington Counties of Pennsylvania.

## **PURPOSE OF THIS DOCUMENT**

- To suggest how the Speech-Language Pathologist might participate in educational problem solving through the pre-referral/screening process.
- To recommend procedures to be used for the assessment of speech and language impairments.
- To define a common set of criteria for the identification of speech and language impairments.
- To recommend ways of documenting the adverse effect on educational performance resulting from a speech and language impairment.
- To establish a common set of criteria for the determination of the severity of speech and language impairments.
- To propose a variety of service delivery options to treat speech and language impairments.
- To recommend a common set of exit criteria for the discontinuation of speech and language service.

# **I. INTRODUCTION**

## **ROLE OF THE SPEECH-LANGUAGE PATHOLOGIST**

Speech-language pathologists are professionally trained to screen, identify, assess, diagnose, refer and provide intervention for students with, or who are at risk for articulation, fluency, voice, language, communication, swallowing, and related disabilities. In addition to engaging in activities to reduce or prevent communication disabilities, speech-language pathologists also counsel and educate families or professionals about these disorders and their management.

School-based speech-language pathologists focus on all three aspects of a student's communication needs: impairment, disability and handicap. The school-based speech-language pathologist (a) prevents, corrects, ameliorates, or alleviates articulation, fluency, voice and language impairments; (b) reduces communication and swallowing disabilities (the functional consequences of the impairment); and (c) lessens the handicap (the social consequences of the impairment or disability).

## FEDERAL/STATE LAW/REGULATIONS

The Individuals with Disabilities Education Act (IDEA) 2004 includes speech-language pathology as a related service and as special education. As related services, speech-language pathology is recognized as "...developmental, corrective, and other supportive services...as are required to assist a child with a disability to benefit from special education...and includes the early identification and assessment of disabling conditions in children." Speech-language pathology is considered special education rather than a related service if the service consists of "specially designed instruction, at no cost to the parents, to meet the unique needs of a child with a disability, including instruction conducted in the classroom, in the home, and in other settings."

Individuals with Disabilities Education Act (IDEA 2004)

Part 300 Federal Regulations (8/2006) and Chapter 14 PA Regulations (6/27/2008)

### 300.8 Child with a Disability

#### Definitions of disability terms

(11) Speech or language impairment means a communication disorder, such as stuttering, impaired articulation, language impairment, or a voice impairment, that adversely affects a child's educational performance.

The determination of speech and language impairment must include the report of a certified speech-language pathologist specifying the nature and degree of the impairment.

- (i) Identification of children with speech or language impairments
- (ii) Diagnosis and appraisal of specific speech or language impairments
- (iii) Referral for medical or other professional attention necessary for the habilitation of speech or language impairments
- (iv) Provisions of speech and language services for the habilitation or prevention of communication impairments
- (v) Counseling and guidance for parents, children, and teachers regarding speech and language impairments

## **PA Act 89 (1975)**

Section 1. Defects of speech and hearing are health-related. They are also the frequent cause of emotional instability in children and are vitally connected to behavior and to learning ability.

Section 3. . . . through the intermediate units. . . shall have the power and duty to furnish free to nonpublic school students, upon the premises of the nonpublic school which they regularly attend, service adequate for the diagnosis and correction of speech and hearing defects.

Intermediate Unit 1 offers speech and language services to nonpublic schools that are Act 89 approved. These services are currently provided to students in grades K-4. An individualized speech/language services plan is developed for any student meeting eligibility criteria. Included in this plan are the student's present levels of performance in the areas of speech and language as well as the target goals and objectives.

Students who may require speech and language services beyond fourth grade can access those services by dually enrolling in their home school district and requesting a complete Chapter 14 evaluation for services.

## II. ELIGIBILITY AND DISMISSAL GUIDELINES

### IDENTIFICATION

One of the roles of the Speech-Language Pathologist is to participate as a member of the evaluation team in identifying students who may be in need of assessments to determine possible eligibility for special education or related services. These assessments assist in determining the presence of disabilities and eligibility/ineligibility for special education and related services as defined under the Individuals with Disabilities Education Act (*IDEA 2004*), Federal Regulations, and Chapter 14 PA Regulations.

The basic phases of the identification process are **pre-referral/ screening** and **referral** when indicated.

### PRE-REFERRAL/SCREENING PHASE

The pre-referral/screening process is the first step in deciding whether a student is in need of referral for a special education/related services evaluation or in need of program modifications within the regular education environment. Many schools establish educational problem-solving teams, with such names as Child Study Team or Instructional Support Team (IST). These teams are defined as school-based problem-solving groups whose purpose is to assist teachers with intervention strategies for dealing with the learning needs and interests of pupils before a formal referral for an evaluation is initiated.

*Screening*, by definition, is a process of selection/elimination of students for evaluation consideration. The screening process is completed through group or individual activities that (1) can be administered in a short period of time and (2) provides a limited sampling of specific speech and language skills. It may include commercially produced screening measures, non-standardized checklists, questionnaires, interviews, or observations administered and interpreted by the SLP. If and when it is the responsibility of the school-based speech-language pathologist to conduct the screenings, the speech-language pathologist:

- selects screening measures meeting standards for technical adequacy
- administers and/or interprets a speech/language screening

However, if the speech and language pathologist identifies a potential speech and language disability during this screening, and strategies for classroom and parent are not successful, the student is referred for evaluation.

During the *pre-referral* phase, it is the responsibility of the Speech-Language Pathologist, as a team participant, to provide **one or more** of the following services as appropriate for specific students:

- Review pertinent school records
- Review classroom modifications and interventions attempted
- Observe the student in the classroom
- Collaborate with parents, teachers, and other professionals to provide strategies, resources, and additional recommendations
- Demonstrate intervention strategies, procedures, and techniques
- Review classroom modifications and interventions attempted
- Provide follow-up consultation
- Gather additional data

Relevant guidance under Chapter 14 PA Regulations includes: (14.122) Screening

- 1) Each school district shall establish a system of screening to accomplish the following:
  - a) Identify and provide initial screening for students prior to referral for a special education evaluation.
  - b) Provide peer support for teachers and other staff members to assist them in working effectively with students in the general education curriculum.
  - c) Conduct hearing and vision screening.
  - d) Identify students who may need special education services and programs.
- 2) Each school district shall implement a comprehensive screening process.
- 3) The screening process shall include:
  - a) Curriculum-based or performance-based assessment.
  - b) Observations
  - c) Interventions
  - d) Student response to interventions
  - e) Determination whether difficulties are due to lack of instruction or English Proficiency or both
  - f) Determination whether student's needs exceed functional ability of the regular education program to maintain the student at an appropriate instructional level
  - g) Activities to gain parent involvement
- 4) If screening activities have produced little or no improvement within 60 school days after initiation, the student shall be referred for evaluation.
- 5) Screening activities do not prohibit a parent from requesting an evaluation at any time, including prior to or during the screening process.

## REFERRAL

When accommodations and interventions have been attempted but have not been successful, any individual, including a parent, teacher, or other service provider, may initiate a referral for assessment. The referral is a formal written request for assessment of a student with suspected special education needs. The assessment focuses on all areas related to a suspected disability that may result in eligibility for special education and/or related services. The written referral includes a brief description of any previously attempted supplementary aids and services, program modifications and supports to the general education environment, a statement regarding the effectiveness of those modifications, and a rationale for the assessment.

When the Speech-Language Pathologist is a member of the Multidisciplinary Team, in accordance with local policies, it may be the responsibility of the speech-language pathologist to:

- Review referrals
- Participate in the development of the assessment plan
- Obtain the results of current hearing/vision screenings and monitor follow-up when appropriate
- Communicate with classroom teacher(s) and parent(s) regarding the status of the referral and to obtain their input
- Obtain written parent/guardian consent for evaluation in accordance with federal mandates, state guidelines, and local policy and procedures
- Complete and distribute the paperwork to process the referral

# ASSESSMENT

A core role of the school-based Speech-Language Pathologist is to conduct a thorough and appropriate speech, language, or communication assessment. A distinction is made between the role of assessment and the role of evaluation. *Assessment* refers to data collection process and the gathering of evidence. *Evaluation* refers to deriving meaning from the data through interpretation, analysis and reflection.

A responsibility of the school-based speech-language pathologist is to select assessment measures that:

- are free of cultural and linguistic bias
- are appropriate for the student's age
- match the stated purpose of the assessment tool to the reported needs of the student
- describe differences when compared to peers
- describe the student's specific communication abilities and difficulties
- elicit optimal evidence of the student's communication competence
- describe real communication tasks

The role of the school-based Speech-Language Pathologist is to evaluate the information gained from all assessment data and make informed decisions about eligibility or placement and subsequent intervention strategies.

# ASSESSMENT PLAN

The first step of the assessment phase is to develop an assessment plan within mandated timelines which documents the areas of speech and language to be assessed, the reason for the assessment, and the names and titles of the personnel who will conduct the assessment. If an initial screening was completed, the results are used to identify the specific areas of speech and language to be addressed.

During assessment data collection, it is the responsibility of the Speech-Language Pathologist to select and conduct an appropriate assessment. This may include:

- Compiling a relevant student history (health, educational, social)
- Collecting descriptive, non-standardized data from parent(s), family, caregivers, teachers, other service-provider professionals and paraprofessionals
- Selecting and administering *appropriate* standardized assessment instruments, including alternative assessment strategies, when indicated
- Obtaining classroom (or other setting) observation of the student

Following screening, students having possible speech and language problems are further evaluated to determine eligibility for program enrollment and specific therapy needs. It is vital that the diagnostic evaluation be thorough and appropriate to the needs of the individual students. No single procedure may be used as the sole criterion for determining whether a child is a child with a disability and for determining an appropriate educational program for the child. Only when all of the information has been compiled and each component reviewed as an integral part of the total behavior of a particular student, is an SLP prepared to plan an IEP.

During assessment data collection, it is the responsibility of the speech- language pathologist to gather information, select appropriate assessment methods, and conduct a balanced assessment.

This balanced assessment may include:

- gathering information from parent(s), family, student, teachers, other service-provider professionals and paraprofessionals
- compiling a student history from interviews and thorough record review
- collecting student-centered, contextualized, performance-based, descriptive, and functional information
- selecting and administering reliable and valid standardized assessment instruments that meet psychometric standards for test specificity and sensitivity

## A Collaborative Process

It is worth emphasizing that a speech and language evaluation is a team endeavor and is comprised of more than just individual test results. In order to demonstrate that the speech and language deviation has an adverse effect on educational performance, evaluation data must be collected from other members of the MDT. The teacher is the principle provider of information regarding the effect on educational performance.

### *Teacher Input*

As a member of the MDT, the teacher must offer information regarding the child's speech and language functioning level within the classroom. Important considerations should be 1) the child's ability to process information (academic and social information) and 2) the child's ability to express information, noting the quality and frequency of speech and language production. Teachers also provide specific information regarding listening, speaking, reading, writing, spelling/invented spelling, and the relationship between the student's communications skills and the curriculum. Teacher-classroom checklists can be used to structure the information collection process from teachers. Teacher Input forms for each speech and language disability are included in every section of the Severity Rating Scales.

### *Parent Input*

The second necessary element is the opportunity for Parent Input. Parents can provide valuable information regarding the child's communicative behavior in various settings and provide additional information about functional and developmental communication levels.

Both the Teacher Input and the Parent Input will give the SLP essential information regarding the child's communicative performance. The SLP should analyze this information to assist in selection of appropriate assessment instruments. The following section describes recommended procedures for the individual assessment portion of the Multidisciplinary Evaluation.

### *Student History*

The speech-language pathologist collects relevant and accurate information through record review, observation, and parent, teacher, or student interviews. Information regarding the student's medical and family history, communication development, social-emotional development, academic achievement from previous education placements, language dominance, community/family language codes and social-behavioral functioning are especially valuable when completing a student case history.

Evaluation procedures must result in a description of the speech and language characteristics manifested by the student **and** the effect of the student's speech and language deficits on his/her educational performance.

## **Standardized Assessment**

When appropriately selected for validity and reliability, standardized tests yield important information regarding language and speech abilities and are part of the comprehensive assessment. They are norm-referenced and used to compare a specific student's performance with that of peers. Statistical scores are valid only for students who match the norming population described in the test manual.

Although all areas of speech, language, and communication are interrelated, broad spectrum, norm-referenced tests may be used to measure such skills of language comprehension and production as syntax, semantics, morphology, phonology, pragmatics, discourse organization, and following directions. Additional tests may be administered to assess such specific areas as auditory abilities and auditory processing of language. Tests are used to assess articulation, phonology, fluency, and voice/resonance; and instrumental and non-instrumental protocols are used to assess swallowing function.

No child should be considered eligible for speech and language services solely on the basis of standardized test results.

## **Criterion Referenced Assessment**

Other assessments may be administered to provide more specific diagnostic or educational planning information. Criterion-referenced assessment may be conducted to determine exactly which specific speech/language skills have been acquired and which skills must be taught.

## **Curriculum-Based Assessment**

Another important area of non-normative assessment addressed by the SLP and assessment team is curriculum-based assessment. This approach extends the evaluation to consider the student's communication skills and deficits within the context of the communication demands of the curriculum and the educational environment.

Curriculum-based assessment addresses the following areas:

- The communication skills and strategies needed by the student to participate in the curriculum,
- The processes and strategies currently exhibited by the student when communicating with the educational environment,
- The new skills, strategies or compensatory techniques the student must acquire to be a more competent participant in the curriculum and educational environment, and
- The curricular modifications that will provide the student with greater opportunities to participate in the educational environment

## **Functional Communication Assessment**

An additional group of students, who need assessment, are students with cognitive-communication impairments. Very few standardized procedures exist that satisfactorily evaluate the communication skills of pre-symbolic or non-verbal students. Therefore, it is necessary to employ structured observation, checklists, and interview techniques in determining the communication forms, functions, and intents of these students. Sometimes standardized assessments can be used in non-standardized ways or informal criterion scales can also be used to assist in planning for this population.

## **Informal Assessment**

Other informal procedures may be administered to supplement the information obtained from norm-referenced assessments. For example checklists and developmental skills, portfolio assessment, and observation/anecdotal records may be used to help determine eligibility for services.

## **Multiple Samples of Communication Performance**

It is important to sample target communication skills in multiple contexts and through varying elicitation techniques so that a valid and representative sample of the student's communication skills is obtained. This is the rationale for the collection of a spontaneous language sample as well as the requirement for demonstration of inadequate functioning on more than one test or sub-test. A spontaneous language sample is analyzed to determine if it provides corroborative evidence for the presence of a communication impairment.

# COMMON CONSIDERATIONS FOR ELIGIBILITY:

## Cognitive Factors

Cognition and language are intrinsically and reciprocally related in both development and function. An impairment of language may disrupt one or more cognitive processes; similarly, an impairment of one or more cognitive processes may disrupt language. Cognitive-based impairments of communication are referred to as cognitive-communication impairments and are disorders that result from deficits in linguistic and nonlinguistic cognitive processes. They may be associated with a variety of congenital and acquired conditions. Speech-language pathologists are integral members of interdisciplinary teams engaged in the identification, diagnosis and treatment of persons with cognitive-communication impairments [American Speech-Language-Hearing Association (ASHA), 2005b, 2005c]. The role of the school speech-language pathologist in evaluating the communication needs of students with cognitive-communication impairments includes:

- collaborating with families, teachers, and others in locating and identifying children whose communication development and behavior may suggest the presence of cognitive impairments or whose communication impairments accompany identified cognitive impairments
- collaborating with other professionals to interpret the relationship between cognitive and communication abilities
- assessing communication requirements and abilities in the environments in which the student functions or will function
- assessing the need for assistive technology including alternative/augmentative communication systems

## **Rejection of Cognitive Referencing**

The practice of excluding students with language problems from eligibility for services when language and cognitive scores are commensurate has been challenged and criticized for more than a decade (National Joint Committee for the Communication Needs of Persons With Severe Disabilities, 2002). First, such comparisons are made based on norm-referenced tests. Second, cognitive referencing is based on the assumption that cognitive skills are prerequisites for language development, and that intelligence measures are a meaningful predictor of whether a child will benefit from language services. Third, scores across tests having different standardization populations and different theoretical bases cannot validly be compared. Fourth, there are no "pure" measures of either verbal or nonverbal abilities; children with language difficulties exhibit problems with nonverbal tasks that could affect their IQ scores, thereby leading to a convergence of test scores. Finally, cognitive referencing for children with cultural differences will be adversely affected by the linguistic bias, format, bias, and content bias prevalent in many formal tests.

IDEA does not require determination of a significant discrepancy between intellectual ability and achievement in order for a child to be eligible for services. In fact, categorical denial of services because of general developmental levels is inconsistent with IDEA's requirement that services be determined on an individual basis.

Determination of eligibility for services should not be made solely on the basis of a discrepancy between language and cognitive measures. Categorical denial without consideration of the student's unique needs and potential to benefit violates federal and state statute, regulation, and policy.

## **Use of Standardized Tests**

While standardized tests are appropriate assessments as part of a comprehensive evaluation, it is inappropriate to use severity cut-off scores (e.g. 1.5 standard deviations below the normative group mean) as the sole determinant of eligibility. Severity cut-off scores can prove arbitrary when applied to a variety of norm-referenced tests. More importantly, this practice does not address the mandate of IDEA to serve children with disabilities because severity is not the sole determinant of whether a condition adversely affects educational performance. A comprehensive assessment should be individually designed and include an appropriate balance of formal and informal assessment instruments and procedures to identify areas of strength and weakness. This quantitative and qualitative assessment examines how the child functions communicatively in the environments in which he or she participates.

## **Adverse Effect on Educational Performance**

The definition of speech or language impairment at the federal and state levels means, “a communication disorder, such as stuttering, impaired articulation, a language impairment or voice impairment that adversely affects a child’s educational performance.”

In order to be deemed a disability, communication impairments must exert an adverse effect on educational performance. Educational performance refers to the student’s ability to participate in the educational process, and must include consideration of the student’s social, emotional, academic, and vocational performance. To the extent that a speech and language impairment affects the student’s ability to participate in active, interactive communication with others in the educational setting, (including peers as well as adults), the student is prevented from participating in the process of education (ASHA, n. d.).

The definition of educational performance must not be limited solely to consideration of academic performance. The student does not need to be below grade level or failing in an academic area to be eligible as speech and language impaired. Examples of students who may be succeeding academically but are still eligible as speech and language impaired include the following:

- A bright student who is dysfluent and has related problems contributing to class discussions, giving book reports, and answering questions orally
- A first grader who is ahead of peers in many areas, but has non- developmental articulation errors that affect intelligibility during “show and tell”, phonics instruction, and other educational activities requiring oral responses
- A third grader who is an above average reader, but whose voice disorder inhibits his/her classroom verbal interactions, resulting in reluctance to give book reports, do oral reading and join in class discussion

Another misconception is that any deviance in communication constitutes a disability. A speech or language deviation does not necessarily constitute an adverse effect on the student's ability to function in the educational setting any more than deviations like mild muscle incoordination or poor eyesight necessarily interfere with educational functioning. Similarly, the speech and language deviation must be shown to interfere with the student's ability to perform in the educational setting before Speech and Language Impaired eligibility is determined.

The effect of the speech and language deviation on social/emotional development also must be carefully considered. The key issue to be addressed is whether the deviation interferes with the student's ability to establish and maintain social relationships and experience sound emotional development. Self consciousness about a speech or language deviation or teasing by peers does not by itself necessarily constitute an impediment to social relationships and emotional development. Careful documentation of limitations of social relationships and sound emotional development must be directly linked with the speech and language deviation to establish the existence of an adverse effect on educational performance.

The documentation of effect on educational performance must clearly indicate two things: the manner in which the student's communication deficit affects his/her performance in the educational setting, and the adverse nature of the effect.

Documentation of the effect on educational performance can be obtained by having the regular education teacher complete a checklist detailing behaviors of the student in the classroom that may indicate an adverse effect on educational performance.

Within this document are suggested checklists to document adverse educational effect related to aural/oral communication.

### **Professional Judgment**

Use of individual professional judgment is essential in determining a severity rating and many clinical judgment factors should be considered.

*Clinical Judgment Factors* to be Considered:

1. The consistency of the inappropriate communication patterns. (How consistent are the specific errors?)
2. The pupil's ability to interact verbally with others. (This would include peer group, teachers, family members.)
3. The effect of the communication problem on school performance.
4. The impact of the communication problem on the listener.
5. The ability of the student to communicate well enough to satisfy his/her needs.
6. The status of speech and language stimulation in the home. (Is there much speech & language in the home? How much do family members communicate with each other? Is there sharing of information? Do parents talk with their children or to them?)
7. The age of the child presenting the problem.
8. The length of time the problem has existed in its current state

One cannot use a criteria & severity rating without also using individual professional judgment. All of these provide an effective combination for the determination of eligibility and need for speech/language support services. A student may not strictly meet the established eligibility criteria, yet team members believe that the student has a disability that adversely affects educational performance and requires special services. In such instances, the team should be allowed to use professional judgment to determine eligibility. Documentation should include a description of the informal and formal measures used to make the determination.

## **Rating Scales**

A communication rating scale reflects communication skills on a continuum, ranging from adequate on one extreme to inadequate at the other. Along that continuum, communication impairments can be classified from mild to severe. This classification process integrates descriptive information about the student's communication skills and their effect on educational performance. The rating scales may be used as guidelines in recommending eligibility for speech/language services and the need for specially designed instruction.

They can also assist in recommending the combination and intensity of programs, services and other resources that may be instituted to enable the student to succeed in his/her educational program. It is recommended that a flexible, multidisciplinary, and cooperative approach be adopted in planning for children with communication impairments. A classification along the continuum provides additional information that facilitates the educational planning process.

The Communication Rating Scales in the following sections of these guidelines can be used to make a classification of severity. Separate rating scales are provided for Articulation, Phonological Processes, Fluency, Language, and Voice. Even though some students may manifest communication impairments in more than one area, it is necessary to rate the student on only one scale. The scale chosen should reflect the impairment area that **most** adversely affects the student's communication performance. However, in making recommendations for speech/language services, the existence of multiple areas of communication impairment should be considered.

## Service Delivery Model

Service delivery to students is the most visible part of IDEA 2004 and is the SLP's most important role with students who have identified communication disorders. Good service delivery systems will allow the SLP to comply with the requirements in IDEA 2004 for a continuum of options, services in the least restrictive environment, and provision for access to the general education curriculum.

The IEP team determines the student's needs as well as the service delivery model. Specific consideration in determining need and type(s) of service delivery models are:

- the severity of the communication impairment
- the effect of the communication impairment on the student's classroom performance and social integration
- the presence of confounding difficulties such as learning disability or hearing impairment
- the age and stage of the student's communicative development (ASHA, 2002)

Using a variety of service delivery models allows the SLP to plan intervention and services to meet individual needs of students, to collaborate with other educational professionals, and to maximize effectiveness of therapy services with students.

There are a variety of service delivery categories through which students receive services. The arrangement of time, resources, location of service, and collaboration among educators comprise the service delivery model/s that will best meet individual student needs. Some service delivery options are as follows:

**MONITOR:** The SLP sees the student for a specified amount of time per grading period to monitor or "check" on the student's speech/language skills. Often this model immediately precedes dismissal.

**COLLABORATIVE CONSULTATION:** The SLP, regular and/or special education teacher(s), and parents/families work together to facilitate a student's communication and learning in educational environments. In this indirect model, the SLP does not provide direct service to the student, but provides guidance and strategies to other team members.

**CLASSROOM BASED:** This model is also known as integrated services, curriculum-based, transdisciplinary, interdisciplinary, or inclusive programming. This is an emphasis on the SLP providing direct services to students within the classroom and other natural environments. Team-teaching by the SLP and the regular and/or special education teacher(s) is frequent with this model. The SLP provides curriculum-based intervention while using materials from the classroom in the least restrictive environment. There are a variety of service delivery configurations included in the classroom-based service delivery model: team teaching, complementary teaching, supportive teaching, parallel teaching, remedial teaching, and station teaching.

**PULL-OUT:** Services are provided to students individually and/or in small groups within the speech/language therapy room or a setting other than the classroom. However, some SLPs may prefer to provide individual or small group services within the physical space of the classroom.

This model may be provided as one of following:

- Individual “pull-out” – Individual intervention. Takes place in speech room or within the physical space of the classroom by SLP.
- Group “pull-out” – Small group intervention. Takes place in speech room or within the physical space of the classroom by SLP. (2-5 students)
- Individual and group “pull-out” – Combination of above.
- Individual “pull-out” and classroom – Both individual “pull-out” services and classroom based intervention by the SLP.
- Group “pull-out” and classroom - Both group “pull-out” services and classroom based intervention by the SLP.
- Group/individual “pull-out” and classroom - Both individual and group “pull-out” services and classroom based intervention by the SLP.

**COMMUNITY BASED:** Communication services are provided to students within the community setting. Goals and objectives focus primarily on functional communication skills.

**COMBINATION:** The SLP provides two or more service delivery options. This list is by no means “exhaustive” and the combinations/models are limited only by the imagination of the team members working with the student. Decisions should be based on student needs(s). It may be helpful to review the model options prior to the IEP development.

Consider the appropriate model, frequency and length of therapy sessions based on:

- Type and severity of communication disorder(s)
- The functioning level of the student
- The length of time the student has been in therapy
- Amount of time student spends out of the classroom while in support services

**Remember:** As the student’s needs change and skills develop, the appropriateness of the service delivery, frequency and length must be re- evaluated and adjusted accordingly. A student may be served in more than one type of service delivery model during the course of his/her individualized program.

## DISMISSAL INFORMATION

The goal of speech/language support services “is to remediate or ameliorate a student's communication disorder such that it does not impede academic achievement and functional performance” (ASHA, n. d., ¶4). It is important for the Speech-Language Pathologist to use sound professional judgment and competency in recommending that services for an eligible student are no longer warranted. When considering dismissal, a reevaluation is necessary if the student will no longer be receiving special education services as a student who is speech/language impaired **only**. The student's IEP Team must review all data to determine if the student is no longer eligible for speech and language support services. The permission to reevaluate is issued **only if additional data is needed**. Parents must be part of this decision making process. The decision to dismiss is based upon IEP Team input (i.e., parents, teacher, specialist(s), etc.) initiated by the SLP or any other team member. If progress is not observed over time, changes must be made in the interventions/accommodations. If continued lack of progress is shown, specific goals and intervention approaches must be re-examined.

If additional progress is not observed, dismissal may be warranted. The student's current academic level, behavioral characteristics and impact on educational performance should be considered when determining dismissal.

If speech and language services are provided as a related service under another disability category such as autism, other health impairment, mental retardation, etc, eligibility for special education services will still apply and other services will continue and eligibility will not be changed. Such decisions must be documented in the IEP Present Education Level and reflected throughout the IEP where appropriate. Parents must be involved in this decision to discontinue speech and language support services as a related service.

Remember, if the speech and language services are provided under the disability category of speech and language impairment, the reevaluation process must be completed.

### **III. ARTICULATION/PHONOLOGICAL PROCESSES**

#### **DEFINITION/ARTICULATION**

According to *Terminology of Communication Disorders/ Speech- Language-Hearing* (5<sup>th</sup> ed., 2004), an articulation impairment is defined as a difficulty in speech-sound (phoneme) production that attracts negative attention, or lessens intelligibility and/or disturbs the speaker. The articulation impairment must adversely affect the student's educational performance in any of the following areas: social interaction, behavior, emotional development, academic, vocational performance and participation in classroom activities and discussions. Articulation errors are characterized by the omission, distortion, substitution, addition and/or sequencing of speech sounds.

#### **DEFINITION/PHONOLOGICAL PROCESSES**

According to *Terminology of Communication Disorders/Speech- Language- Hearing* (5<sup>th</sup> ed., 2004), phonological processes are techniques used by children to simplify speech when attempting to produce adult words.

Phonological processes apply to larger segments that *include* individual sounds. A phonological process is more all encompassing and includes the changes that occur to individual sounds and their distinctive features. Phonological processes describe what children do in the normal developmental process of speech to simplify standard adult productions. When a child uses many different processes or uses processes that are not typically present during speech acquisition, intelligibility may be impaired. The advantage of using a phonological processes approach to speech therapy is that the SLP can identify error patterns and then target these patterns to remediate more than one sound at a time. Most phonological processes are seen in normal speech acquisition. Children typically outgrow these processes and learn to produce them in the correct adult targets by 8 years of age. The most common phonological processes that occur in normal speech acquisition are unstressed syllable deletion, final consonant deletion, gliding and cluster reduction.

# ARTICULATION/PHONOLOGICAL PROCESSES ELIGIBILITY/ENTRY CRITERIA

A student may meet eligibility criteria for services as a student who is speech/language impaired in the area of articulation/phonological processes when any of the following adversely effect educational performance:

- Sound errors/phonological processing errors exceed the developmental guidelines
- Substitution, distortion, lateralization, or omission of sounds are secondary to organic or neurological problems (i.e., cleft palate, cerebral palsy, hearing impairment, apraxia, dysarthria)
- Speech intelligibility is less than expected for the child's age
- A lateral lisp is observed at any age

## Additional Considerations:

- Degree of intelligibility
- Level of maturation
- Stimulability

Students are not eligible for services when exhibiting the following:

- Sound errors/phonological processing errors are consistent with normal development.
- Articulation differences are due primarily to unfamiliarity with the English language, dialectical differences, temporary physical disabilities or environmental, cultural or economic factors.
- Tongue thrust unless frontal substitutions for sibilants are present.
- Dental structure that prevents successful articulation therapy.
- The articulation errors/phonological processing errors do not interfere with educational performance and do not require specially designed instruction.

# ARTICULATION/PHONOLOGICAL PROCESSES ASSESSMENT

An articulation evaluation gathers information about sound production in words, sentences, and conversational speech. Evaluation procedures should include imitative as well as spontaneous speech sampling utilizing informal/formal assessments. Analysis of a student's speech should consider phonological process development, sound production, and sound sequencing skills.

## Assessment Procedures:

- Collect data obtained during the pre-referral process
- Obtain classroom teacher input
- Obtain parent input
- Conduct a classroom observation
- Examine the oral/motor structures and functioning
- Obtain results from most recent hearing screening
- Review student's school records and/or reports from other agencies
- Administer a formal test of articulation and/or phonology
- Elicit a spontaneous speech sample to assess intelligibility and phoneme production patterns in connected speech
- Evaluate stimulability
- Conduct supplemental assessments as needed for such areas as auditory discrimination
- When a multiple articulation/phonological problem exists, it is recommended that a broad based language screening test be administered to explore the possibility of a concomitant language impairment
- Complete the articulation profile scale or the phonological process profile scale
- Complete the articulation/phonological process severity rating scale

## **ARTICULATION/PHONOLOGICAL DISMISSAL/EXIT CRITERIA**

The criteria for exit from services for speech and language impairments should be discussed with IEP team members at the beginning of intervention.

A STUDENT WILL BE RECOMMENDED FOR DISMISSAL WHEN ANY OF THE FOLLOWING OCCUR:

1. Correct production of the target phoneme or phonological process is reached at the level designated on the IEP and specially designed instruction is no longer required.
2. Articulation/phonological skills are commensurate with overall functioning and expectations and no longer interfere with the student's ability to perform in the educational setting.
3. There is a lack of progress in articulation/phonological skills documented over time as evidenced by probes, therapy data, and/or teacher/parent/guardian input/consultation.
4. The student demonstrates a lack of motivation, consistent incompleteness of assignments or inappropriate behaviors that are not conducive to therapy, such as not being cooperative, chronic absenteeism, verbally or physically disrupting the therapy session. Attendance records and pertinent observations must be included in the documentation that indicate a variety of learning styles, service delivery models, and motivators that were utilized to address the student's behavior and performance.
5. Other associated and/or handicapping conditions, specifically, dental abnormalities, velopharyngeal insufficiency, or inadequate physiologic support for speech prevents the student from benefiting from further therapy.
6. Withdrawal is requested by the parent/guardian. This must be obtained in writing and agreed to by the educational team.

### III. FORMS/INSTRUCTIONS

Following are rating scales and input forms that will assist the SLP with the diagnosis of an articulation or phonological processing disorder:

- Instructions for Scoring the Articulation Profile
- Articulation Profile
- Instructions for Scoring the Phonological Processes Profile
- Phonological Processes Profile
- Teacher Input – Articulation/Phonological Processes
- Parent Input – Articulation/Phonological Processes
- Classroom Observation/Checklist for Speech/Language Impaired
- Oral Facial Examination
- Assessment of Articulation and Phonological Processes
- Instructions for Scoring the Articulation/Phonological Processes Severity Rating Scale
- Articulation/Phonological Processes Severity Rating Scale

### **Instructions for Scoring the Articulation Profile:**

Use the Articulation Profile provided to compare the child's **chronological/developmental age** to his/her **articulation performance**. If you believe the cognitive ability of the student is within normal limits, (approximate IQ of 70 or above), use his/her chronological age as the expected level of articulation performance. If you believe the student's ability may be below his/her chronological age, you will need an estimate of his/her level of cognitive functioning to compare to his/her current performance. If the developmental age is below chronological age, use the developmental age on the Articulation Profile.

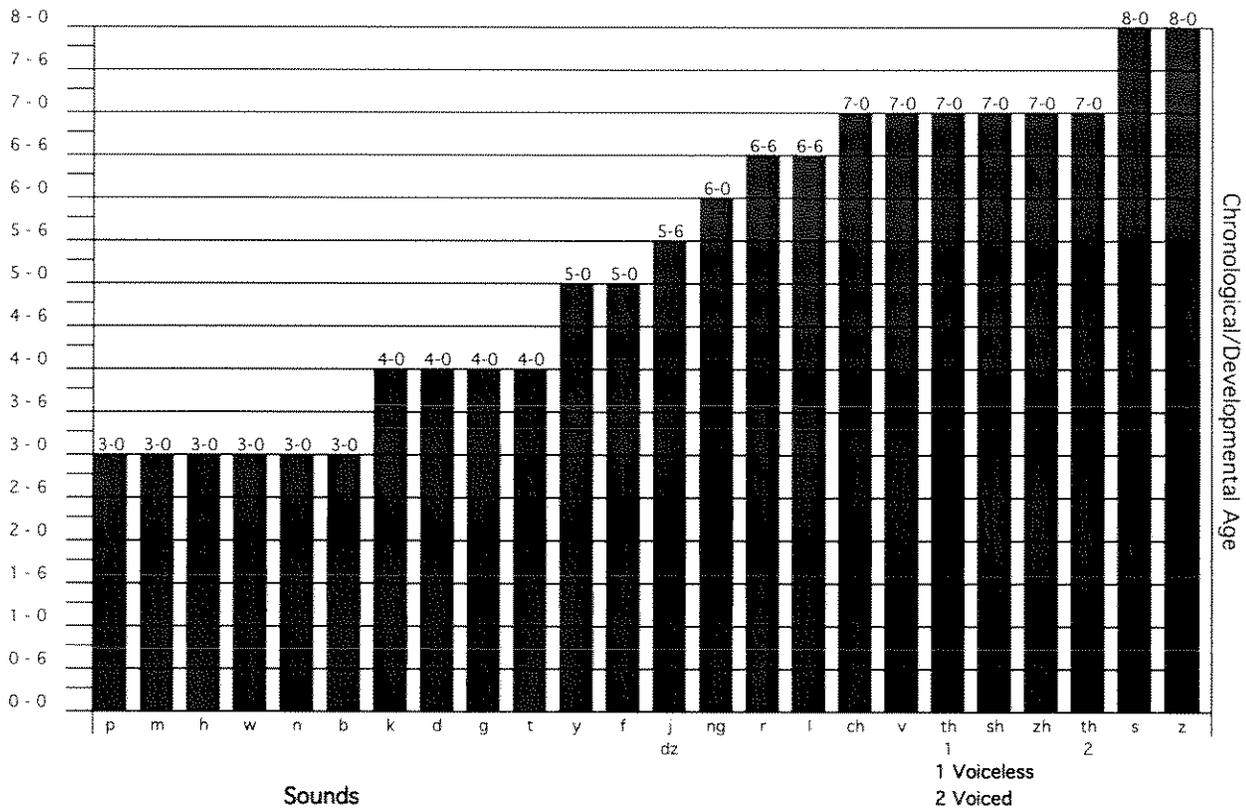
The following steps are to be followed when completing the Articulation Profile:

1. Draw a horizontal line to indicate the developmental age/chronological age of the student.
2. Draw horizontal lines indicating one year and two years below the developmental age/chronological age of the student.
3. Draw an "X" on the top of the phoneme bar to indicate error phonemes. The top of the phoneme bar indicates the age at which 90% of all children are customarily producing that sound.

Identify any error phonemes that are **6 months or more below** the student's developmental age/chronological age.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_ SLP: \_\_\_\_\_

### ARTICULATION PROFILE



This developmental sound chart is based on norms taken from Arizona Articulation Proficiency Scale, Third Revision (2000); Developmental Articulation and Phonology Profile (1997); and the Goldman Fristoe 2 Test of Articulation (2000). Each solid bar represents a sound. It stops at the age level that 90% of all children are customarily producing that sound. Vowels are usually developed between ages of 3 and 6 and are found in the Developmental Articulation and Phonology Profile (1997).

### **Instructions for Scoring the Phonological Process Profile:**

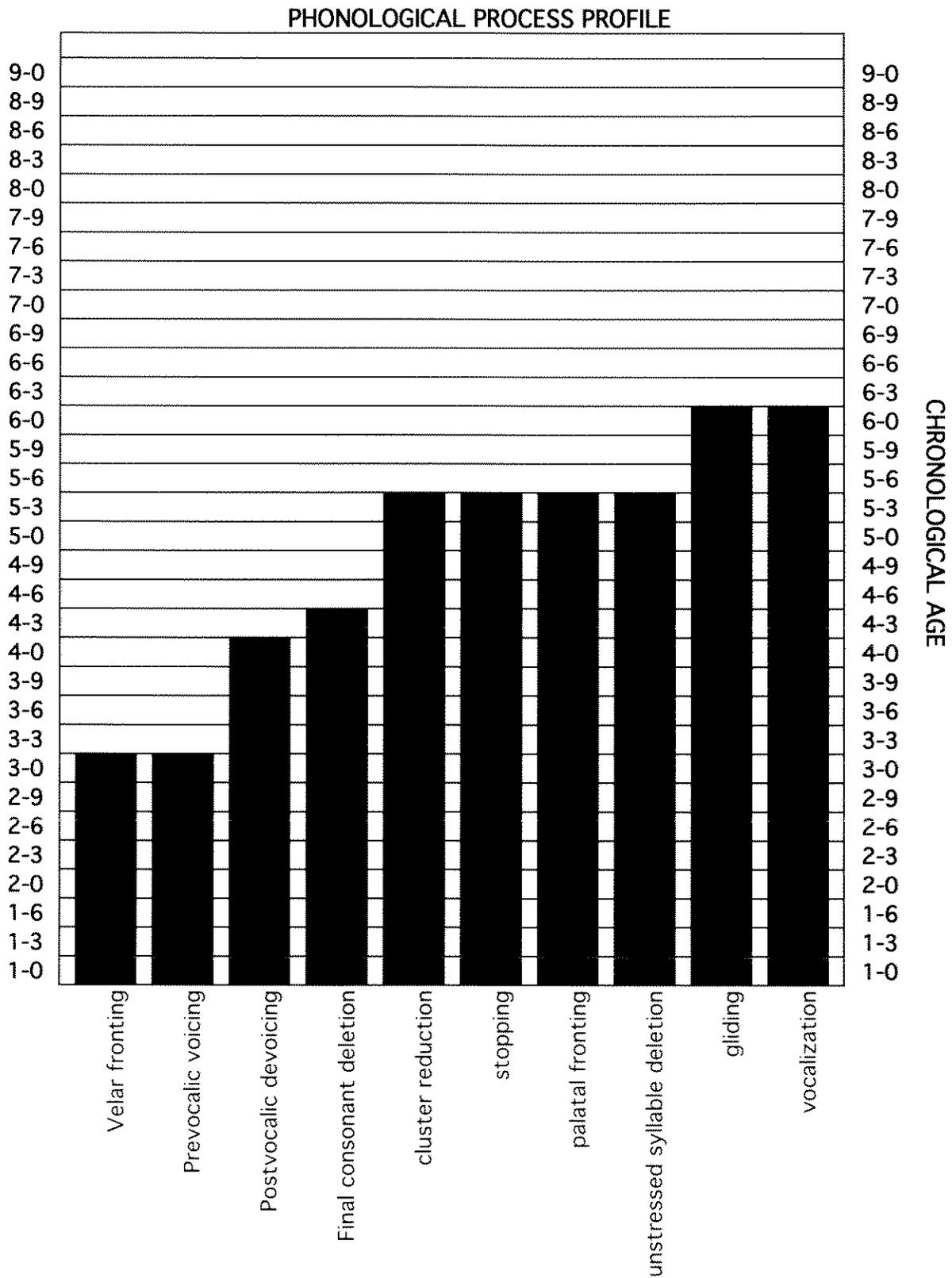
Use the Phonological Process Profile provided to compare the child's **chronological age** to his/her **sound structure performance**. ( Sound structure performance includes speech sounds and the rules for combining these sounds into words.)

The following steps are to be followed when completing the Phonological Process Profile:

1. Draw a horizontal line to indicate the chronological age of the student.
2. Draw horizontal lines indicating one year and two years below the chronological age of the student.
3. Draw an "X" on the top of the process bar to indicate error patterns. Each bar indicates the age range during which processes are normally extinguished.

Identify any process patterns that are **6 months or more below** the student's chronological age.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_ SLP: \_\_\_\_\_



This chart is based on the Developmental Articulation and Phonology Profile from Academic Communication Associates (1997). Each bar indicates the age range during which processes are normally extinguished.

## Teacher Input – Articulation/Phonological Processes

Student \_\_\_\_\_ School \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

*Your observations and responses concerning the above student will help determine if a sound production or phonological processing problem exists which adversely affects educational performance. (Note: Educational performance refers to the student's ability to participate in the educational process and must include consideration of the student's social, emotional, academic and vocational performance.)*

Please return the completed form to the speech/language therapist by \_\_\_\_\_ (date)

	Yes	No	Sometimes	N/A
1. Is this student's intelligibility reduced to the extent that you find it difficult to understand him/her? If yes, check appropriate description: ___ Occasional Difficulty ___ Frequent Difficulty ___ Considerable Difficulty Student's speech is ___% intelligible even though some sound errors may be present. <i>Check one:</i> ___25% ___50% ___70% ___80% ___90% ___100%	_____	_____	_____	_____
2. Does this student appear frustrated or embarrassed because of his/her production errors?	_____	_____	_____	_____
3. Does the student avoid speaking in class or in other situations because of his/her production errors?	_____	_____	_____	_____
4. Has this student ever expressed concern about his/her production errors?	_____	_____	_____	_____
5. Does the student's speech distract listeners from what he/she is saying?	_____	_____	_____	_____
6. Does the student have age-appropriate awareness of sounds in words and ability to rhyme, segment, and manipulate sounds in words?	_____	_____	_____	_____
7. Does the student make the same errors when reading aloud as he/she does when speaking?	_____	_____	_____	_____
8. Does the student have difficulty discriminating sounds and/or words from each other?	_____	_____	_____	_____
9. Does the student make spelling errors that appear to be associated with speaking errors?	_____	_____	_____	_____
10. Does the student self-correct articulation errors?	_____	_____	_____	_____
11. Does the student have reading problems due to articulation problems?	_____	_____	_____	_____
12. Does the student mispronounce during reading of words containing error sounds?	_____	_____	_____	_____
13. Rate the impact of the student's speech errors on his/her social, emotional, academic and/or vocational functioning. <i>Check one:</i> ___does not interfere ___minimal impact ___interferes ___seriously limits	_____	_____	_____	_____

Do you have any other observations relating to the articulation/phonological skills of this student? \_\_\_\_\_

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## Parent Input – Articulation/Phonological Processes

**Student:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Teacher:** \_\_\_\_\_

**Grade/Program:** \_\_\_\_\_

*Please complete all of the following questions relating to your child's speech. Your observations and responses concerning your child will help determine if a sound production problem exists which adversely affects educational performance. (Note: Educational performance refers to the student's ability to participate in the educational process and must include consideration of the student's social, emotional, academic and vocational performance.)*

Please return the completed form to the speech/language therapist by \_\_\_\_\_ (date)

	Yes	Sometimes	No	N/A
1. Does your child speak clearly?				
2. Is your child understood by family and friends?				
3. Can your child repeat speech sounds?				
4. Does your child say sounds clearly but is not able to use them in words or sentences?				
5. Do you feel your child has problems in reading, spelling, language or other academic subjects because of his/her articulation errors?				
6. Does your child's articulation errors seem to create social isolation?				
7. Has your child ever indicated that he/she is having problems producing sounds when speaking or shown concern about his/her sound production?				
8. Has your child ever self-corrected any of his/her own articulation errors?				
9. Does your child's speech problem distract listeners from what he/she is saying?				
10. Is your child's intelligibility reduced to the extent that you find it difficult to understand him/her? If yes, check appropriate description: ___Occasional Difficulty ___Frequent Difficulty ___Considerable Difficulty Student's speech is ___% intelligible even though some sound errors may be present. Check one: ___25% ___50% ___70% ___80% ___90% ___100%				
11. Rate the impact of the student's speech errors on his/her social, emotional, academic and/or vocational functioning. Check one: ___does not interfere ___minimal impact ___interferes ___seriously limits				

Please indicate any significant information in your child's medical history (e.g., hospitalizations, accidents, medications, audiological evaluations, etc.) that would be helpful in determining your child's articulation needs:

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Please indicate any suggestions you have that would assist in meeting your child's articulation needs:

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**Classroom Observation Form**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Class: \_\_\_\_\_

Observer: \_\_\_\_\_

**PRIOR TO OBSERVATION**

**Review Records:**

**Teacher Concerns**

**Student Preparation for/Attention to Instruction:**

**Yes No Sometimes N/A**

- Is prepared for class
- Materials/desk appear organized
- Homework is completed
- Body language indicates positive attitude
- Appears to pay attention
  - In large group
  - In small group
  - In one-on-one
- Stays in seat or work area
- Takes notes
- Follows along in text
- Participates in discussions
- Attends to auditory/visual/multimodality instruction
- Follows two or more speakers
- Remain on-task during observational period

**Student Response to Instructional Style:**

- Asks questions for clarification
- Requests assistance from teacher/peers
- Asks for repetition of instructions
- Answers oral questions with appropriate/related response
- Responds to written instruction
- Looks to others for clues
- Requires additional response time
- Works without reinforcement
- Responds to concrete/verbal reinforcement

**Student Behavior:**

- Follows classroom rules & routine
- Works independently
- Accepts errors/constructive criticism
- Appears accepted by peers
- Seems to like other students

**Student Behavior: (Continued)**

**Yes No Sometimes N/A**

Seems aware of speech/language difficulties  
Uses free time constructively

**Student's Communicative Proficiency:**

**Articulation/Phonology**

Makes sound errors (list sound errors/phonological processes  
you observe child using: \_\_\_\_\_)  
Uses dialectal pattern other than Standard English  
Has difficulty sequencing sounds in multisyllabic words  
Intelligibly interferes with communication

**Voice**

Rate is too fast or too slow  
Voice quality is harsh, breathy, nasal, hoarse  
Voice is intermittently or completely lost  
Pitch is too high or too low  
Volume is too loud or too soft

**Fluency**

Fluency is interrupted by repetitions  
Fluency is interrupted by prolongations or injections  
Fluency is interrupted by secondary characteristics  
Speech causes student frustration  
Speech pattern seems to interfere with communication  
Student hesitates to speak in class  
Others comment on student's speech

**Language**

Maintains eye contact when speaking  
Speaks in complete sentences  
Uses correct question form  
Uses subject-verb agreement  
Uses pronouns correctly  
Uses negation  
Uses plural forms correctly  
Uses appropriate verb tense  
Uses complex sentences  
Uses precise vocabulary  
Appears to have adequate vocabulary  
No apparent word retrieval difficulties  
Relates stories in correct sequence  
Responds correctly to general comprehension questions  
Responds correctly to comprehension questions about specific oral instruction  
Responds correctly to comprehension questions about written passage  
Comprehends concepts of time, space, quantity, quality and directionality



## ORAL FACIAL EXAMINATION

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Examiner: \_\_\_\_\_ Date: \_\_\_\_\_

**INSTRUCTIONS:** *Observe the physical appearance/movement of the oral mechanism.  
Circle the corresponding descriptions in each category.*

### I. FACE

1. symmetry: normal/droops on right/droops on left
2. abnormal movements: none/grimaces/spasms
3. mouth breathing: yes/no
4. comments: \_\_\_\_\_

### II. LIPS

*Evaluate appearance of student's lips.*

1. shape: normal/abnormal
2. size: normal/abnormal

*Tell student to pucker.*

1. range of motion: normal/reduced
2. symmetry: normal/droops bilaterally/droops right/droops left
3. strength (*press tongue blade against lips*): normal/weak
4. comment: \_\_\_\_\_

*Tell the student to smile.*

1. range of motion: normal/reduced
2. symmetry: normal/droops bilaterally/droops right/droops left
3. comment: \_\_\_\_\_

*Tell student to puff cheek and hold air.*

1. lip strength: normal/reduced
2. nasal emission: absent/present
3. comment: \_\_\_\_\_

### III. JAW AND TEETH

*Tell student to open and close mouth.*

1. range of motion: normal/reduced
2. symmetry: normal/deviates to right/deviates to left
3. movement: normal/jerky/groping/slow/asymmetrical
4. TMJ noises: absent/grinding/popping

*Observe dentition of student.*

1. occlusion (molar relationship):  
normal  
neuroclulsion (upper and lower arches are correct relationship to each other and to rest of skull – Class I)  
distoclusion (the lower jaw is too far back in relation to the upper arch rest of skull – Class II)  
mesioclulsion (the lower jaw is too far forward in relationship to the upper dental arch and rest of skull – Class III)
2. teeth: all present/dentures/teeth missing (specify)\_\_\_\_\_
3. arrangement of teeth: normal/jumbled/spaces/misaligned
4. occlusion (incisor relationship):  
normal/openbite/overbite/underbite/crossbite/wears orthodontics
5. hygiene:\_\_\_\_\_

#### IV. TONGUE

1. surface color: normal/abnormal
2. abnormal movements: absent/jerky/spasms/writhing
3. size: normal/small/large
4. frenum: normal/short

#### V. LIPS-JAW-TONGUE DIFFERENTIATION:

1. ability to protrude: easy/difficult/not at all
2. ability to retract: easy/difficult/not at all
3. range of motion-left/right: normal/reduced
4. range of motion-up/down: normal/reduced
5. ability to produce tongue pop – normal/reduced

#### VI. TONSILS/ADENOIDS:

1. removed: yes/no
2. size: normal/enlarged/inflamed

#### VII. HARD AND SOFT PALATES:

1. color: normal/abnormal
2. alveolar ridge: normal/very prominent
3. arch height: normal/high/low
4. arch width: normal/narrow/wide
5. fistula (minute opening): absent/present
6. clefting: absent/present

VIII. BREATHING MECHANISM:

1. mouth breather: yes/no
2. adequate for speech purposes: yes/no
3. irregular pattern: shallow/jerky

IX. NASAL CAVITY/RESONANCE:

1. appearance: normal/blockage
2. hyponasal: appropriate/mild/moderate/severe
3. hypernasal: appropriate/mild/moderate/severe
4. audible nasal emission: intermittent/continuous

X. ORAL HABITS:

1. thumb sucking: yes/no
2. tongue sucking: yes/no

XI. DIADOCHOKINESES:

**Instructions:** Time the number of seconds it takes your student to complete each task the prescribed number of times. The average number of seconds for children from 6 to 13 years of age is reported in the right-hand side of the table.

The standard deviation (SD) from the norm (mean or average) is also found in the table. Subtract the SD from the norm to determine each SD interval. For example, using the /pʌ/ norm with a 6-year-old, 3.8 (4.8-1.0) is one SD, 2.8 (4.8-2.0) is two SDs, 2.3 (4.8-2.5) is two-and-a-half SDs, etc. Therefore, a 6 year-old child who needed 2.6 seconds to complete the /pʌ/ sequence would be two SDs below the mean.

			<i>Norms in seconds for diadochokinetic syllable rates</i>							
			<i>Age:</i>							
Task	Repetitions	Seconds	6	7	8	9	10	11	12	13
pʌ	20	_____	14.8	14.8	4.2	4.0	3.7	3.6	3.4	3.3
tʌ	20	_____	14.9	14.9	4.4	4.1	3.8	3.6	3.5	3.3
kʌ	20	_____	15.5	15.3	4.8	4.6	4.3	4.0	3.9	3.7
	Standard Deviation:		11.0	11.0	0.7	0.7	0.6	0.6	0.6	0.6
pʌtʌkʌ	10	_____	10.3	10.0	8.3	7.7	7.1	6.5	6.4	5.7
	Standard Deviation:		12.8	12.8	2.0	2.0	1.5	1.5	1.5	1.5

**ASSESSMENT OF ARTICULATION AND PHONOLOGICAL PROCESSES**

**Results of Spontaneous Speech Sample**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Examiner: \_\_\_\_\_

*Instructions: Obtain a spontaneous speech sample from the student. Transcribe articulation errors evident in the student's connected speech.*

*Then summarize your findings to identify error patterns.*

Sound	Connected Speech Errors		
	Initial	Medial	Final
p	_____	_____	_____
m	_____	_____	_____
h	_____	_____	_____
w	_____	_____	_____
n	_____	_____	_____
b	_____	_____	_____
k	_____	_____	_____
d	_____	_____	_____
g	_____	_____	_____
t	_____	_____	_____
y	_____	_____	_____
f	_____	_____	_____
j (dz)	_____	_____	_____
ng	_____	_____	_____
r	_____	_____	_____
l	_____	_____	_____
ch	_____	_____	_____
v	_____	_____	_____
th (1)	_____	_____	_____
sh	_____	_____	_____
zh	_____	_____	_____
th (2)	_____	_____	_____
s	_____	_____	_____
z	_____	_____	_____

Additional comments concerning student's articulation during conversational speech.

**Instructions:** Obtain a spontaneous speech sample from the student. Transcribe the phonological processing errors evident in the student's connected speech and check the processes identified.

- \_\_\_\_\_ Velar fronting
- \_\_\_\_\_ Prevocalic voicing
- \_\_\_\_\_ Postvocalic devoicing
- \_\_\_\_\_ Final consonant deletion
- \_\_\_\_\_ Cluster reduction
- \_\_\_\_\_ Stopping
- \_\_\_\_\_ Palatal fronting
- \_\_\_\_\_ Unstressed syllable deletion
- \_\_\_\_\_ Gliding
- \_\_\_\_\_ Vocalization

## **Instructions for Scoring the Articulation/Phonological Processes Severity Rating Scale:**

The purpose of the articulation/phonological processes severity rating scale is to provide a quantitative and qualitative assessment of the severity of an individual's production of phonemes, phonological processes and overall speech. The categories included in the rating scale are: 1) Sound Production, 2) Stimulability, 3) Oral Motor and/or Motor Sequencing, 4) Intelligibility and 5) Effect on Educational Performance. Using the articulation/phonological process profile and other clinical impressions, the speech pathologist assesses the quality of speech by using a numerically weighted scale that ranges from 0 to 28. Zero to 9 on the continuum indicates no problems with speech production/phonological processes and upper values (25-28) indicate severe problems with speech production/phonological processes.

When rating an individual's speech, the clinician should always focus on the client's ***total speech production*** and not on the impact of isolated errors of articulation. For example, if an individual has three misarticulations, the scaled scores for the respective categories should reflect/consider the severity of the errors in the context of the person's overall speech/communication. Thus, theoretically, two of the errors of articulation could be severe, one could be mild and there may be no significant, adverse impact on general speech intelligibility and educational performance.

The following steps are to be followed when completing the Severity Rating Scale:

1. Circle the score for the most appropriate "description" for each of the four categories (i.e., Sound Production, Stimulability, Oral Motor and/or Motor Sequencing, Intelligibility and Effect on Educational Performance.
  - a. Reminder: Although you are rating the severity of specific errors of articulation, your scores for the various categories must reflect the severity of the error(s) in the context of the person's ***total/overall speech production***.
2. Compute the total score by adding the values for each category scored.

3. Circle total score on the bar/scale at the bottom of the table. The severity of the individual's errors of articulation is classified on the bar/scale as normal/adequate, mild, moderate or severe.
4. Answer yes or no to the final statements at the bottom of the form.

Student: \_\_\_\_\_  
 School: \_\_\_\_\_

Date: \_\_\_\_\_  
 SLP: \_\_\_\_\_

**ARTICULATION/PHONOLOGICAL PROCESSES SEVERITY RATING SCALE**

	<b>0</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>Sound Production</b>	Student's speech is characterized by <b>no</b> sound errors or errors consistent with normal development.	Student's speech is characterized by sound errors <b>6 mos. to one year below</b> developmental age/chronological age.	Student's speech is characterized by sound errors from <b>one to two years below</b> developmental age/chronological age.	Student's speech is characterized by sound errors more than two years below developmental / chronological age.
<b>Stimulability</b>	Most error sounds are <b>stimulable</b> for correct production in <b>several contexts</b> .	Most error sounds are <b>stimulable</b> in at least <b>one context</b> .	Although not correct, most error sounds <b>approximate</b> correct production.	<b>No</b> error sounds are <b>stimulable</b> for correct production.
<b>Oral Motor and/or Motor Sequencing</b>	Oral motor and/or sequencing <b>adequate</b> for speech production.	Oral motor and/or sequencing difficulties are minimal and do not contribute to speech production problems.	Oral motor and/or sequencing difficulties interfere with speech production.	Oral motor and/or sequencing greatly interfere with speech production, use of cues, gestures or AD needed.
	<b>0</b>	<b>4</b>	<b>6</b>	<b>8</b>
<b>Intelligibility</b>	Connected speech is <b>intelligible</b> .	Connected speech is <b>intelligible</b> some errors noticeable; more than <b>80% intelligible</b> .	Connected speech <b>sometimes</b> unintelligible when context is unknown; <b>50-80%</b> intelligible.	Connected speech mostly unintelligible; gestures/cues usually needed; less than 50% intelligible.
<b>Effect on Educational Performance Social Emotional Academic Vocational</b>	<b>No interference</b> with the child's participation in educational setting. Acquisition of basic cognitive and/or affective performance skills is <b>not</b> affected.	<b>Minimal impact</b> on the child's participation in the educational setting. Acquisition of basic cognitive and/or affective performance skills <b>may</b> be affected.	<b>Does interfere</b> with child's participation in the educational setting. Acquisition of basic cognitive and/or affective performance skills <b>is</b> usually affected.	<b>Seriously limits</b> child's participation in the educational setting. Acquisition of basic cognitive and/or affective performance skills <b>is</b> usually affected.
<b>Total Score</b>	<b>0 2 3 4 5 6 7 8 9</b>	<b>10 11 12 13 14 15 16</b>	<b>17 18 19 20 21 22 23 24</b>	<b>25 26 27 28</b>
<b>Rating Score</b>	<b>Normal/Adequate</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>

Based on compilation of the assessment data, this student scores in the *Mild*, *Moderate* or *Severe* range or the Articulation Severity Rating Scale.

YES       NO

This assessment provides documentation/supporting evidence of adverse effects of the Speech Sound production on educational performance.

YES       NO

**(BOTH STATEMENTS ABOVE MUST BE CHECKED YES)**

## IV. LANGUAGE

### DEFINITION/LANGUAGE

According to *Terminology of Communication Disorders/Speech- Language-Hearing* (5<sup>th</sup> ed., 2004), a language disorder is defined as the following: (a) any difficulty with the production and/or reception of linguistic units, regardless of environment, which may range from total absence of speech to minor variance with syntax; meaningful language may be produced, but with limited content (e. g., reduced vocabulary; restricted verbal formulations; omission of articles, prepositions, tense and plural markers; paucity of modifiers); (b) inability or limited ability to utilize linguistic symbols for communication; and (c) any interference with the ability to communicate effectively in any community as dictated by the norms of that community.

The language disorder must adversely affect the student's educational performance, or in the case of a preschool-aged child, have an adverse effect on the child's development.

The disorder may involve:

- The form of language
  - phonology – the sound system of the language
  - morphology – the system that governs the structure of words and the construction of word forms
  - syntax – the system governing the order and combination of words to form sentences and the relationships among the elements within a sentence
- The content of language
  - semantics – the system that governs the meanings of words and sentences
- The function of language in communication in any combination
  - pragmatics – the system that combines the above language components in functional and socially appropriate communication

## LANGUAGE ELIGIBILITY/ENTRY CRITERIA

- A student may meet eligibility criteria for services as a student who is speech/language impaired in the area of language when standardized and/or curriculum based assessment results reveal language that is not adequate for success in the regular education curriculum as verified by members of the educational team.
- Standard deviation scores and severe discrepancy scores can be considered, but cannot be the sole factor in determining eligibility.

### **Additional Considerations:**

#### **ESL:**

According to IDEA, a child shall not be determined to be a child with a disability if the determining factor is limited to English proficiency. Unless it is documented by an ESL specialist that the student has deficits in the native language, ESL students should not receive a language evaluation. The ESL specialist should assess communication competency. Learning English as a second language is a normal process and not a delay or disorder; therefore, if a child is learning English, he is not eligible for language therapy.

#### **Written Language / Reading:**

Although written language and reading can be used as a support or reinforcement for language remediation, it is not the responsibility of the SLP to remediate written language and reading deficits. This responsibility lies with the regular education or special education teacher.

#### **ADD/ADHD:**

When evaluating children who have a medical diagnosis of Attention Deficit Disorder or Attention Deficit Hyperactivity disorder, an attempt should be made to distinguish between the symptoms of ADD/ADHD and the characteristics of a language disorder. Much of the information for a differential diagnosis can be acquired through classroom observations and teacher interview. Several factors can aid in the distinction:

- a. if a child understands part of the time, but not all of the time, then it is not a language disorder because language
- b. disorders are not intermittent
- c. if instructions need to be repeated frequently, but not reworded, simplified or interpreted, the problem could be
- d. attentional rather than a language deficit
- e. when a child understands when he is paying attention, but has difficulty catching up when he has not been
- f. paying attention, he does not have a problem with receptive language
- g. students in upper elementary or secondary grade levels
- h. who have language deficits will often need help interpreting comprehension questions from reading or discussion, locating and reasoning through the written material to locate the answers, integrating the information and producing the answer.

If the student is able to accomplish written work with a minimum of help, he is not likely to have a language disorder.

Students are not eligible for services when exhibiting the following:

- Language deficits, which do not interfere with educational or social performance and do not require specially designed instruction.
- Language differences which are primarily due to environmental or cultural factors including non-standard English and regional dialect.

## LANGUAGE ASSESSMENT

A language evaluation gathers descriptive data on a student's skills in the listener and speaker role.

Receptively, the evaluation should determine the student's ability to hear, discriminate, assign significance to and interpret spoken words, phrases, clauses, sentences, and discourse. It should also determine the student's ability to understand the intent of the speaker.

Expressively, the evaluation should determine if the student has the ability to formulate ideas or thoughts, find words, construct sentences, and produce oral/non-oral language. It should also determine the student's ability to use appropriate language successfully to communicate in different speaking situations and for different purposes.

### Assessment Procedures:

- Collect data obtained during the pre-referral process
- Obtain classroom teacher input
- Obtain parent input
- Conduct a classroom observation
- Obtain results of most recent hearing screening
- Administer formal/informal assessments
- Review student's school records and/or reports from other agencies
- Elicit a spontaneous communication sample to assess semantics, morphology, syntax and pragmatics in connected speech
- Complete the language severity rating scale

## LANGUAGE DISMISSAL/EXIT CRITERIA

The criteria for exit from services for speech and language impairments should be discussed with IEP team members at the beginning of intervention.

A STUDENT WILL BE RECOMMENDED FOR DISMISSAL WHEN ANY OF THE FOLLOWING OCCUR:

1. The decision to dismiss should be based upon IEP team input (i.e., parents, teacher, specialist(s), etc) initiated by the SLP or any other team member.
2. Goals and objectives have been achieved at the level designated on the IEP and specially designed instruction is no longer required.
3. If progress is not observed over time, changes must be made in the interventions/accommodations. If continued lack of progress is shown, specific goals and intervention approaches must be re-examined. If additional progress is not observed, dismissal may be warranted.
4. The student's current academic level, behavioral characteristics and impact on educational performance should be considered when determining dismissal.
5. Language skills as measured by standardized language tests are commensurate with overall functioning and expectations and no longer interfere with the student's ability to perform in the educational setting.
6. The student consistently demonstrates a lack of motivation, consistent incompleteness of assignments or inappropriate behaviors that are not conducive to therapy, such as not being cooperative, chronic absenteeism, verbally or physically disrupting the therapy session. Attendance records and pertinent observations must be included in the documentation that indicate a variety of learning styles, service delivery models, behavior interventions and motivators that were utilized to address the student's behavior and performance.
7. Withdrawal is requested by parent/guardian. This must be obtained in writing and agreed to by the educational team.

## IV. FORMS/INSTRUCTIONS

Following are rating scales and input forms that will assist the SLP with the diagnosis of a language impairment:

- Instructions for scoring the language severity rating scale
- The language severity rating scale
- Teacher Input - Language
- Parent Input – Language
- Classroom Observation/Checklist for Speech and Language Impairment
- Procedures for Obtaining a Language Sample
- Worksheet for Recording a Language Sample
- Mean Length of Utterance
- Procedures for Determining the Mean Length of Utterance
- Assessment of Morphologic Features
- Determining the Type-token Ratio
- Type-token Ratio for the Analysis of Semantic Skills
- Assessment of Syntactic Skills
- Assessment of Pragmatic Skills
- SLP Checklist- Oral Expression
- Informal Language Assessment Checklist

## **Instructions for Scoring the Language Severity Rating Scale:**

The purpose of the severity rating scale is to provide a quantitative and qualitative assessment of the severity of an individual's language impairment. The categories included in the rating scale are: 1) formal diagnostic assessments, 2) informal assessments, 3) functional/academic language skills, and 4) effect on educational performance. Using formal/informal assessments and other clinical impressions, the speech pathologist assesses the quality of language by using a numerically weighted scale that ranges from 0 to 20. Zero to 5 on the continuum indicates no problems with language skills and upper values (16-20) indicate severe problems with language skills.

When rating an individual's language skills, the clinician should always focus on the degree to which the language impairment affects the student's overall educational performance.

The following steps are to be followed when completing the Language Severity Rating Scale:

1. Circle the score for the most appropriate "description" for each of the four categories (i.e., Formal Diagnostic Assessment, Informal Assessments, Functional/Academic Language Skills and Effect on Educational Performance).
2. Compute the total score by adding the values for each category scored.
3. Circle total score on the bar/scale at the bottom of the table. The severity of the individual's language impairment is classified on the bar/scale as normal/adequate, mild, moderate or severe.
4. Answer yes or no to the final statements at the bottom of the form.

**\*Reminder:** Although you are rating the severity of the specific language deficits, your scores for the various categories must reflect the severity of the deficits in the context of the student's overall language performance.

Student: \_\_\_\_\_  
 School: \_\_\_\_\_

Date: \_\_\_\_\_  
 SLP: \_\_\_\_\_

### LANGUAGE SEVERITY RATING SCALE

	<b>0</b>	<b>2</b>	<b>3</b>	<b>4</b>
Formal Diagnostic Assessment Comprehensive, standardized, measure(s) and scores	Student scores are within: • 1.5 Standardized Deviation (SD) below mean; • Standard Score (SS) of 78 or above; and/or • 17 percentile or above in expected language performance.	Student scores are: • 1.5 - 2 SD below mean; • LQ of SS of 70-77; and/or • 2 - 6 percentile in expected language performance.	Student scores are: • 2 - 2.5 SD below mean; • LQ or SS of 62-69; and/or • 1st-2nd percentile.	Student scores more than: • 2.5 SD below the mean; • LQ or S at or below 62: and/or • below 1st percentile.
Informal Assessment Check descriptive tool used: Language / Communication Sample Checklist(s) Observations  Other: _____	Language skills are within expected range	Check areas of weakness: Sentence length/complexity Word order/syntax Vocabulary/semantics Word finding Word form/morphology Use of language/pragmatics Auditory perception	At least two of the following areas are deficient Check areas of weakness: Sentence length/complexity Word order/syntax Vocabulary/semantics Word finding Word form/morphology Use of language/pragmatics Auditory perception	At least three of the following areas are deficient. Check areas of weakness: Sentence length/complexity Word order/syntax Vocabulary/semantics Word finding Word form/morphology Use of language/pragmatics Auditory perception
Functional Academic Language Skills	Functional/Academic Language skills within expected range	The student performs effectively most of the time with little or no assistance required.	The student needs more cues, models, explanations, and checks on progress or assistance than the typical student.	The student does not perform effectively most of the time, despite the provision of general education modifications and support.
	<b>0</b>	<b>4</b>	<b>6</b>	<b>8</b>
Effect on Educational Performance. Social Emotional Academic Vocational	No interference with child's participation in educational setting. Acquisition of basic cognitive and/or affective performance skills is not affected.	Minimal impact on the child's participation in educational setting. Acquisition of basic cognitive and/or affective performance skills may be affected.	Does interfere with child's participation in educational setting. Acquisition of basic cognitive and/or affective performance skills is usually affected.	Seriously limits child's participation in educational setting. Acquisition of basic cognitive and/or affective performance skills is impaired.
<b>Total Score</b>	<b>0 2 3 4 5</b>	<b>6 7 8 9 10</b>	<b>11 12 13 14 15</b>	<b>16 17 18 19 20</b>
<b>Rating Scales</b>	<b>Normal / Adequate</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>

- Yes  No Based on compilation of the assessment data, this student scores in the Mild, Moderate or Severe range for a Language Disability.
- Yes  No There is documentation/support evidence of adverse effects of the Language Disability on educational performance.
- \*Standard scores are based on a mean of 100 and a standard deviation of 15.  
 The standard score can be a receptive, expressive or total language quotient.

## Teacher Input – Language

Student \_\_\_\_\_ School \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

Your observation of the above student's language will help determine if a language problem adversely affects educational performance. (Note: Educational performance refers to the student's ability to participate in the educational process and must include consideration of the student's social, emotional, academic and vocational performance.) **Check all age-appropriate items that have been observed.**

Please return the completed form to the speech/language therapist by \_\_\_\_\_ (date)

### Skill Area: Listening – Auditory Processing – Memory – Receptive Language

The student:	<i>*Not age appropriate</i>	Yes	No	Sometimes
<ul style="list-style-type: none"> <li>• Can follow verbal directions during...               <ul style="list-style-type: none"> <li>Individual instruction</li> <li>Group instruction</li> </ul> </li> </ul>				
<ul style="list-style-type: none"> <li>▪ Can follow classroom routines</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Requires clarification and/or repetition of directions</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Uses appropriate listening/attending skills</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Comprehends verbal information provided in class</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Comprehends questions</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Answer questions appropriately</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Can problem solve</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Can ignore auditory distractions</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Retains new information</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Recalls old information</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Comprehends simple sentence structures</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Comprehends complex sentence structure:               <ul style="list-style-type: none"> <li>Passive voice (The boy was followed by the dog.)</li> <li>Relative clauses (The cake that Joy ate.)</li> <li>Pronoun reference (he=Billy)</li> </ul> </li> </ul>				
<ul style="list-style-type: none"> <li>▪ Is the student's reading comprehension appropriate</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Comprehends basic curricular concepts</li> </ul>				
<b>Skill Area: Semantics – Concepts</b>				
<ul style="list-style-type: none"> <li>▪ Can predict outcomes</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Can draw inference</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Recognizes different uses of words, depending on context:               <ul style="list-style-type: none"> <li>Recognizes meanings of antonyms and synonyms</li> <li>Recognizes multiple meaning (fly: a fly, to fly)</li> <li>Recognizes figurative language (hold your horses)</li> <li>Differentiates homonyms (road – rode)</li> <li>Understands temporal (before/after), position (above/below), and Quantitative (more/several) concepts</li> </ul> </li> </ul>				
<ul style="list-style-type: none"> <li>▪ Understands adult language (proverbs, idioms, humor)?</li> </ul>				

**Skill Area: Expressive Language**

The student:	<i>*Not age appropriate</i>	Yes	No	Sometimes
<ul style="list-style-type: none"> <li>▪ Expresses ideas effectively</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Uses sentence structure and grammar that is appropriate for age/grade</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Asks WH-questions</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Expresses a logical sequence of ideas to tell a story or relate event</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Uses age-appropriate vocabulary</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Speaks with appropriate rate, volume, pitch, and voice quality</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Uses age-appropriate speech sounds</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Does the student contribute appropriately to class discussions</li> </ul>				
<b>Skill Area: Social Communication/Pragmatics</b>				
<ul style="list-style-type: none"> <li>▪ Participates in discussions</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Can carry on a meaningful conversation with adults and peers</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Begins, maintains, and ends conversation appropriately</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Makes relevant comments about the topic</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Understands humor, idioms, and other figurative language</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Attends to speaker – maintains eye contact appropriately</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Asks for clarification when message is not understood</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Recognizes when the listener does not understand and attempts to clarify the message</li> </ul>				
<b>Skill Area: Metalinguistics/Phonemic Awareness</b>				
<ul style="list-style-type: none"> <li>▪ Participates in discussions</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Can identify rhyming words</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Can verbally produce rhyming words</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Can identify initial consonant sounds in words presented orally</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Can blend sounds orally to form words</li> </ul>				
<ul style="list-style-type: none"> <li>▪ Can segment sounds within a word orally</li> </ul>				

*It is my opinion that these behaviors \_\_\_do/ \_\_\_do not adversely affect the student's educational performance.*

Comments:

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## Parent Input – Language

**Student:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Teacher:** \_\_\_\_\_

**Grade/Program:** \_\_\_\_\_

*Please complete all of the following questions relating to your child's language. Your observations and responses concerning your child will help determine if there is a significant problem with language that adversely impacts educational performance. (Note: Educational performance refers to the student's ability to participate in the educational process and must include consideration of the student's social, emotional, academic and vocational performance).*

Please return the completed form to the speech/language therapist by \_\_\_\_\_ (date)

	Yes	Sometimes	No	N/A
1. Does your child appear to understand your speech and that of other individuals when they are speaking to him/her?				
2. Does your child appear to comprehend others by demonstrating knowledge of what is conveyed through actions as opposed to speech (e.g., pointing to a chair as a directive to sit down as opposed to "saying" sit down)?				
3. Has a hearing test been conducted to rule out a hearing loss as a possible difficulty?				
4. Does your child have a history of repeated middle ear fluid / infections?				
5. Does your child appear to know the meanings of words and concepts (e.g., colors, categories of items and locations) that are developmentally appropriate for his/her age?				
6. Does your child use language appropriately during play, meeting and greeting people, and conversing with friends and family?				
7. Is your child usually successful in requesting, commenting and answering questions about objects, actions, etc.? (Note that any mode of communication is acceptable for this item).				
8. Is your child usually successful in using one or more modes of communication (e.g., verbal, sign, pointing or augmentative and alternative communication devices)?				
9. Does your child answer "yes/no" questions verbally?				
10. Does your child answer "yes/no" questions with gesturing (i.e., nodding or other means)?				
11. Can your child follow simple one step directions?				
12. Can your child follow complex directions (more than two steps)?				

	Yes	Sometimes	No	N/A
13. Does your child demonstrate language at an ability level that suffices learning new information?				
14. Do you feel your child has problems in reading, spelling, language or other academic subjects because of his/her language difficulties?				
15. Rate the impact of your child's language skills on his/her social, emotional, academic and/or vocational functioning. <i>Check one:</i> _____ does not interfere _____ minimal impact _____ interferes _____ seriously limits				

Please indicate any significant information in your child's medical history (e.g., hospitalizations, accidents, medications, audiological evaluations, etc) that would be helpful in determining your child's speech needs:

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Please indicate any suggestions you have that would assist in meeting your child's speech needs:

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**Classroom Observation Form**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Class: \_\_\_\_\_

Observer: \_\_\_\_\_

**PRIOR TO OBSERVATION**

**Review Records:**

**Teacher Concerns**

**Student Preparation for/Attention to Instruction:**

**Yes No Sometimes N/A**

- Is prepared for class
- Materials/desk appear organized
- Homework is completed
- Body language indicates positive attitude
- Appears to pay attention
  - In large group
  - In small group
  - In one-on-one
- Stays in seat or work area
- Takes notes
- Follows along in text
- Participates in discussions
- Attends to auditory/visual/multimodality instruction
- Follows two or more speakers
- Remain on-task during observational period

**Student Response to Instructional Style:**

- Asks questions for clarification
- Requests assistance from teacher/peers
- Asks for repetition of instructions
- Answers oral questions with appropriate/related response
- Responds to written instruction
- Looks to others for clues
- Requires additional response time
- Works without reinforcement
- Responds to concrete/verbal reinforcement

**Student Behavior:**

- Follows classroom rules & routine
- Works independently
- Accepts errors/constructive criticism
- Appears accepted by peers
- Seems to like other students

**Student Behavior: (Continued)**

**Yes No Sometimes N/A**

Seems aware of speech/language difficulties  
Uses free time constructively

**Student's Communicative Proficiency:**

**Articulation/Phonology**

Makes sound errors (list sound errors/phonological processes  
you observe child using:\_\_\_\_\_)  
Uses dialectal pattern other than Standard English  
Has difficulty sequencing sounds in multisyllabic words  
Intelligibly interferes with communication

**Voice**

Rate is too fast or too slow  
Voice quality is harsh, breathy, nasal, hoarse  
Voice is intermittently or completely lost  
Pitch is too high or too low  
Volume is too loud or too soft

**Fluency**

Fluency is interrupted by repetitions  
Fluency is interrupted by prolongations or injections  
Fluency is interrupted by secondary characteristics  
Speech causes student frustration  
Speech pattern seems to interfere with communication  
Student hesitates to speak in class  
Others comment on student's speech

**Language**

Maintains eye contact when speaking  
Speaks in complete sentences  
Uses correct question form  
Uses subject-verb agreement  
Uses pronouns correctly  
Uses negation  
Uses plural forms correctly  
Uses appropriate verb tense  
Uses complex sentences  
Uses precise vocabulary  
Appears to have adequate vocabulary  
No apparent word retrieval difficulties  
Relates stories in correct sequence  
Responds correctly to general comprehension questions  
Responds correctly to comprehension questions about specific oral instruction  
Responds correctly to comprehension questions about written passage  
Comprehends concepts of time, space, quantity, quality and directionality



## Procedures For Obtaining A Language Sample

Language sampling is a vital part of a complete evaluation of language. There are several aspects of collecting a language sample that are especially important for assessing language disorders:

- ❑ Collect a representative sample, with a minimum of 50-100 utterances. Since language is so multifaceted, it may be necessary to sample your client's language for 30 minutes or even more (Bloom & Lahey, 1978; Miller, 1981).
- ❑ Vary the contexts and activities used to elicit the sample to assess different language features.
- ❑ If possible, ask others to interact with the client during the sample, such as another clinician, a peer, a parent or caregiver, or a teacher. Children commonly vary their language use depending on the audience.
- ❑ Collect multiple samples.
- ❑ Tape record or video tape (if possible) the sample for later analysis.

The following guidelines are adapted from Bloom and Lahey (1978), Hubbell (1988), Owens (1995), and Retherford (1993). These can be useful when transcribing the language sample:

- ❑ Transcribe the entire sample.
- ❑ Indicate the speaker for all utterances. For example, mark A for adult (or P for partner) and C for client or child. Create your own abbreviations as needed.
- ❑ Use phonetic symbols only to transcribe unintelligible or partially intelligible utterances. A dash (-) can also be used to indicate each unintelligible word. For example, "I want - -" indicates a four-word utterance with two unintelligible words.
- ❑ Capitalize only proper nouns and the pronoun *I*.
- ❑ Keep punctuation to a minimum.
- ❑ Indicate utterance endings with a slash (*/*).
- ❑ Number the client's utterances as you proceed.
- ❑ Transcribe utterances consecutively from the tape. The first few utterances may be omitted since this could be considered a "warming up" period.

The language sample can be used to calculate the students mean length of utterance, and for helping to assess the student's morphologic, semantic, syntactic and pragmatic skills. Information from the language sample can also be utilized when completing any of the informal assessment checklists.





## **The Mean Length of Utterance**

The mean length of utterance (MLU) is the average number of morphemes (or words, as will be described later) that a client produces in an utterance. MLU provides important information about language development, and it is one indicator of a language delay or disorder. Generally, a normal child's chronological age (up to age 5) will correspond closely to his/her MLU (Brown, 1973). For example, a normally developing 4-year, 3-month-old child will often exhibit an MLU of approximately 4.3 (plus or minus a few tenths). This method of interpretation is very general and must, of course, be used with caution when diagnosing or ruling out language disorders. Remember, children develop language at varying rates.

## Procedures for Determining the Mean Length of Utterance

Once the language sample is transcribed, you are ready to calculate your client's MLU. The first step is counting the morphemes in each utterance. Lund and Duchan (1993) outline specific do's and don'ts for computing mean length of utterance.<sup>1</sup>

Exclude from your count:

- *Imitations* which immediately follow the model utterance and which give the impression that the child would not have said the utterance spontaneously.
- *Elliptical answers* to questions which give the impression that the utterance would have been more complete if there had been no eliciting question (e.g., "Do you want this?" "Yes." "What do you have?" "My dolls").
- *Partial utterances* which are interrupted by outside events or shifts in the child's focus (e.g., "That's my —oops").
- *Unintelligible utterances*, that contain unintelligible segments. If a major portion of a child's sample is unintelligible, a syllable count by utterance can be substituted for morpheme count.
- *Rote passages* such as nursery rhymes, songs, or prose passages which have been memorized and which may not be fully processed linguistically by the child.
- *False starts and reformulations* within utterances which may either be self-repetitions or changes in the original formulation (e.g., "I have one [just like] almost like that"; ([We] we can't").
- *Noises* unless they are integrated into meaningful verbal materials such as "He went xx."
- *Discourse markers* such as *um, oh, you know* not integrated into the meaning of the utterance (e.g., "[Well] it was [you know] [like] a party or something").
- *Identical utterances* that the child says anywhere in the sample. Only one occurrence of each utterance is counted. If there is even a minor change, however, the second utterance is also counted.
- *Counting or other sequences of enumeration* (e.g., "blue, green, yellow, red, purple").
- *Single words or phrases* such as "hi," "thank you," "here," "know what?"

Count as one morpheme:

- Uninflected lexical morphemes (e.g., *run, fall*) and grammatical morphemes that are whole words (articles, auxiliary verbs, prepositions).
- Contractions when individual segments do not occur elsewhere in the sample apart from the contraction. If either of the constituent parts of the contraction are found elsewhere, the contraction is counted as two rather than one morpheme (e.g., *I'll, it's, can't*).
- *Catenatives* such as *wanna, gonna, hafta* and the infinitive models that have the same meanings (e.g., *going to go*). This eliminates the problem of judging a morpheme count on the basis of the child's pronunciation. Thus *am gonna* is counted as two morphemes.

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<sup>1</sup> From N. Lund and J. Duchan, *Assessing Children's Language in Naturalistic Contexts*, 3<sup>rd</sup> ed., © 1993, pp. 205-206. Adapted by permission of Prentice-Hall, Englewood Cliffs, NJ.

- Phrases, compound words, diminutives, reduplicated words which occur as inseparable linguistic units for the child or represent single items (e.g., *oh boy; all right; once upon a time; a lot of; let's; big wheel; horsie*).
- Irregular past tense. The convention is to count these as single morphemes because children's first meanings for them seem to be distinct from the present tense counterparts (e.g., *did, was*).
- Plurals which do not occur in singular form (e.g., *pants; clothes*), including plural pronouns (*us; them*).
- Gerunds and participles that are not part of the verb phrase (*Swimming* is fun; He was *tired*; That is the *cooking* place).

Count as more than one morpheme:

- Inflected forms: regular and irregular plural nouns; possessive noun; third person singular verb; present participle and past participle when part of the verb phrase; regular past tense verb; reflexive pronoun; comparative and superlative adverbs and adjectives.
- Contractions when one or both of the individual segments occur separately any-where in the child's sample (e.g., *It's* if *it* or *is* occurs elsewhere).

After you have counted all the morphemes, you are already to calculate the MLU. The traditional method of calculating MLU is dividing the number of morphemes by the number of utterances. For example:

$$\frac{150 \text{ morphemes}}{50 \text{ utterances}} = 3.0 \text{ MLU}$$

Many clinicians also calculate the MLU for words by dividing the number of words by the number of utterances. This calculation does *not* reflect the use of bound morphemes (e.g., *-ing, -ed, -s, etc.*); therefore, the MLU for words will always be equal to or smaller than the MLU for morphemes. For example, the same 100-word sample might have:

$$\frac{100 \text{ words}}{50 \text{ utterances}} = 2.0 \text{ MLU-words}$$

$$\frac{120 \text{ morphemes}}{50 \text{ utterances}} = 2.4 \text{ MLU-morphemes}$$

MLU is a gross but reasonably accurate index of grammatical development up to four-to-five morphemes (Brown 1973; James, 1993). It is considered gross because the MLU is a General measure which tells us nothing about specific forms or structures used. However, the use of both free and bound morphemes is needed for utterance lengths to increase.

## Assessment of Morphologic Features

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Examiner: \_\_\_\_\_

**Instructions:** Analyze your client's language sample and/or ask structured questions to assess morphologic features. Make a plus (+) or a (√) if the client's attempt is correct and a minus (-) or a zero (0) if the attempt is incorrect. Make additional comments in the right-hand column.

### Plurals

### Comments

\_\_\_\_\_ /z/ as in *trees* \_\_\_\_\_

\_\_\_\_\_ /s/ as in *books* \_\_\_\_\_

\_\_\_\_\_ /vz/ as in *wolves* \_\_\_\_\_

\_\_\_\_\_ /ðz/ as in *dishes* \_\_\_\_\_

\_\_\_\_\_ irregular such as *feet* \_\_\_\_\_

### Possessive

\_\_\_\_\_ /z/ as in *boy's* \_\_\_\_\_

\_\_\_\_\_ /s/ as in *cat's* \_\_\_\_\_

\_\_\_\_\_ /ðz/ as in *mouse's* \_\_\_\_\_

### Articles

\_\_\_\_\_ a \_\_\_\_\_

\_\_\_\_\_ the \_\_\_\_\_

### Present progressive tense

\_\_\_\_\_ /ɪn/ as in *eating* \_\_\_\_\_

### Past tense

\_\_\_\_\_ /d/ as in *spilled* \_\_\_\_\_

\_\_\_\_\_ /t/ as in *dropped* \_\_\_\_\_

\_\_\_\_\_ /ðd/ as in *melted* \_\_\_\_\_

\_\_\_\_\_ irregular such as *broke* \_\_\_\_\_

### Third person singular

\_\_\_\_\_ /z/ as in *moves* \_\_\_\_\_

\_\_\_\_\_ /s/ as in *walks* \_\_\_\_\_

\_\_\_\_\_ /ðz/ as in *pushes* \_\_\_\_\_

### Comparatives/superlatives

\_\_\_\_\_ /ð/ as in *softer* \_\_\_\_\_

\_\_\_\_\_ /ðst/ as in *smallest* \_\_\_\_\_

\_\_\_\_\_ irregular such as *best* \_\_\_\_\_

### Negation

\_\_\_\_\_ /ʌn/ as in *unhappy* \_\_\_\_\_

\_\_\_\_\_ not as in *not now* \_\_\_\_\_

### Reflexive pronouns

\_\_\_\_\_ /self/ as in *myself* \_\_\_\_\_

### Prepositions

\_\_\_\_\_ in \_\_\_\_\_

\_\_\_\_\_ on \_\_\_\_\_

\_\_\_\_\_ under \_\_\_\_\_

\_\_\_\_\_ behind \_\_\_\_\_

\_\_\_\_\_ beside \_\_\_\_\_

\_\_\_\_\_ between \_\_\_\_\_

\_\_\_\_\_ in front \_\_\_\_\_

## Determining The Type-token Ratio

The type-token ratio (TTR) is an easy-to-calculate measure of functional vocabulary skills. The ratio reflects the diversity of words used by the client during the language sample. Templin (1957) reported that normally developing children between the ages of 3 and 8 years have TTRs of .45-.50. A substandard TTR is one indicator of an expressive language delay or disorder. Remember, though, you must avoid using this kind of normative data as a single or primary method for establishing a diagnosis.

After you have transcribed the language sample, number every new word produced by the child. The last number you write is the number of different words produced. To calculate the TTR, divide the number of different words by the total number of words in the sample. For example:

$$\frac{100 \text{ different words}}{200 \text{ total words}} = .50 \text{ TTR}$$

Retherford (1993) presents a modification of the TTR. Rather than count all the different words, count the different *types* of words used in the sample. She uses eight different word types: nouns, verbs, adjectives, adverbs, prepositions, pronouns, conjunctions, affirmative (*yeah, okay, etc.*) and negatives (*no, not, etc.*), articles, and wh- words (*who, where, etc.*) Calculations are made by dividing the number of each different type of word by the total number of words in the sample. This method allows you to evaluate the diversity of word types used by your client. Form 6-5, "Type-token Ratio for Assessment of Semantic Skills," is a worksheet you can use to itemize word-type frequencies for the TTR calculation. Under the appropriate column, record first-time productions of each word noted during the language sample. Each time your client uses a word already recorded, tally the repeated production next to the original entry. For example:

go		(1 production of this word)
in	✓	(2 productions)
me	✓✓✓	(4 productions)
no	✓✓✓✓✓✓	(7 productions)

## Type-token Ratio for the Analysis of Semantic Skills<sup>1</sup>

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Examiner: \_\_\_\_\_

**Instructions:** Under the appropriate word-type column, record first-time utterances of every word. Repeated productions of the same word are marked with a tally next to the original entry. Count total productions of every different word and total productions of every different word type and enter in the summary section.

Nouns	Verbs	Adjectives	Adverbs	Prepositions

---

<sup>1</sup> Excluding the identifying information and instructions sections, this form is from K. Retherford (1993), *Guide to Analysis of Language Transcripts* (2<sup>nd</sup> ed., pp. 80-81). Eau Claire, WI: Thinking Publications. Used by permission.

Pronouns	Conjunctions	Negative/ Affirmative	Article	Wh-Words

**Summary**

Total Number of Different: \_\_\_\_\_  
 Nouns \_\_\_\_\_  
 Verbs \_\_\_\_\_  
 Adjectives \_\_\_\_\_  
 Adverbs \_\_\_\_\_  
 Prepositions \_\_\_\_\_  
 Pronouns \_\_\_\_\_  
 Conjunctions \_\_\_\_\_  
 Negative/Affirmative \_\_\_\_\_  
 Articles \_\_\_\_\_  
 Wh-Words \_\_\_\_\_

**Total Number of Different Words** \_\_\_\_\_

Total Number of:  
 Nouns \_\_\_\_\_  
 Verbs \_\_\_\_\_  
 Adjectives \_\_\_\_\_  
 Adverbs \_\_\_\_\_  
 Prepositions \_\_\_\_\_  
 Pronouns \_\_\_\_\_  
 Conjunctions \_\_\_\_\_  
 Negative/Affirmative \_\_\_\_\_  
 Articles \_\_\_\_\_  
 Wh-Words \_\_\_\_\_

**Total Number of Words** \_\_\_\_\_

$$\frac{\text{Total Number of Different Words}}{\text{Total Number of Words}} = \text{_____} = \text{Type token Ratio (TTR)}$$





## Assessment of Pragmatic Skills

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Examiner: \_\_\_\_\_

**Instructions:** Use activities such as those suggested in the right-hand column to elicit the desired pragmatic behaviors. Mark a plus (+) or a check (✓) if the response is correct or appropriate and a minus (-) or a zero (0) if the response is incorrect, not present, or inappropriate.

### *Pragmatic Behavior:*

\_\_\_\_\_ respond to greetings

\_\_\_\_\_ make requests

\_\_\_\_\_ describe events

\_\_\_\_\_ take turns

\_\_\_\_\_ follow commands

\_\_\_\_\_ make eye contact

\_\_\_\_\_ repeat

\_\_\_\_\_ attend to tasks

### *Sample Activities:*

Observe the client's response when you say, "Hi! How are you?"

Put your hand out to shake hands.

Ask the client to draw a circle but don't immediately provide a pencil.

Ask "What would you say to your mom if you were in the grocery store and wanted a candy bar?"

Ask the client what he/she did this morning.

Ask the client to tell you about a holiday or a special occasion.

Ask the client to alternately count or recite the alphabet with you (e.g., you say *a*, client says *b*, you say *c*, client says *d*, etc.).

Take turns telling 1-2 lines of *The Three Bears* or another children's story.

Ask the client to turn his/her paper over & draw a happy face or a square.

Say to the client, "Touch your ears, then clap, your hands twice."

Consider whether the client has maintained normal eye contact during other parts of this assessment.

Ask the client to tell you his/her address and/or phone number.

Ask the client to repeat the following sentences:

Michael is 7 years old.

The oven door is open.

She got a new book for her birthday.

Consider how the client has attended to this assessment.

Ask the client to describe a picture you provide.

*Pragmatic Behavior:*

\_\_\_\_\_maintain topic

\_\_\_\_\_role-play

\_\_\_\_\_sequence actions

\_\_\_\_\_define words

\_\_\_\_\_categorize

\_\_\_\_\_understand object functions

\_\_\_\_\_initiate activity/dialogue

*Sample Activities:*

Ask the client to tell you about a recent movie or TV show he/she has watched.

Ask the client to describe a hotdog.

Ask the client to be the “teacher” for a while & give you things to complete.

Pretend you are in a fast-food restaurant. Tell the client to be the cashier while you pretend to be the customer.

Ask the client to describe the steps involved in making the bed, buying groceries, or writing a letter.

Ask the client to describe how to make a hamburger or salad, or prepare breakfast.

Ask the client to define words such as:

scissors  
kitchen  
computer

Ask the client if the following words are days or months:

Sunday  
June  
April  
Wednesday

Ask the client to name several farm animals, foods, or sports.

Ask the client to show you how to use scissors.

Ask what a ruler is used for.

Place an odd-looking object on the table & see if the client asks what it is.

Observe the client with his/her parents, teacher, or with other children.

## Speech/Language Pathologist Checklist – Oral Expression

Student: \_\_\_\_\_ Date: \_\_\_\_\_

SLP: \_\_\_\_\_

Yes	No	Sometimes	<b>The Student:</b>
_____	_____	_____	1. States identifying information: name ( ), age ( ), birthday ( ), Phone number ( ), and family information ( )
_____	_____	_____	2. Uses correct grammatical structure for variety of purposes <ul style="list-style-type: none"> <li>a. Formulates sentence correctly</li> <li>b. Uses subject/verb appropriately</li> <li>c. Uses verb tenses appropriately</li> <li>d. Asks questions correctly: yes/no ( ), and “wh” questions ( )</li> <li>e. Answers questions correctly: yes/no ( ), and “wh” questions ( )</li> <li>f. Uses negation correctly</li> <li>g. Uses pronouns correctly: personal ( ), demonstrative [this/that] ( ), reflexive [herself/myself] ( )</li> <li>h. Formulates plurals correctly: regular ( ) and irregular ( )</li> </ul>
_____	_____	_____	3. Labels common objects correctly
_____	_____	_____	4. Uses age appropriate vocabulary
_____	_____	_____	5. Uses appropriate location ( ), temporal ( ), and quantitative ( ) expressions for age level (e.g., above/below, before/after, more/several)
_____	_____	_____	6. Makes eye contact when speaking
_____	_____	_____	7. Carries on a conversation with appropriate voice level
_____	_____	_____	8. Knows how to begin, maintain, and end a conversation
_____	_____	_____	9. Restates thoughts in alternative form
_____	_____	_____	10. Tells stories or relates information in the proper sequence with beginning, middle, and/or end
_____	_____	_____	11. Uses speech rather than gestures to express self
_____	_____	_____	12. Speaks easily without seeming to be frustrated

Yes	No	Sometimes	<b>The Student:</b>
_____	_____	_____	13. Accounts for listener's shared background when formulating expression (e.g., uses pronouns and articles only with clear referents; gives enough information about the topic)
_____	_____	_____	14. Responds correctly to humor ( ), sarcasm ( ), and figures of speech ( )
_____	_____	_____	15. Recognizes when to match voice level and intonation to a variety of situations <ul style="list-style-type: none"> <li>a. Place (playground, classroom, assembly)</li> <li>b. Intent (question/answer in class, show emotions, give reports)</li> </ul>

**Informal Language Assessment Checklist**  
*(Documentation of observation and analysis of language sample)*

Student: \_\_\_\_\_ CA: \_\_\_\_\_ Examiner: \_\_\_\_\_ Date of Test: \_\_\_\_\_

**THIS CHILD CURRENTLY EXHIBITS THE FOLLOWING STRENGTHS AND WEAKNESSES**

*(Only skills observed during evaluation session will be marked, i.e., formal testing, interview, conversation)*

**P = skill present**  
**A = skill absent**  
**E = skill emerging**

CONCEPTS/SEMANTICS	PROCESSING/SYNTAX	MORPHOLOGY	
_____ Spatial	_____ Answer Yes/No questions	_____ Plural markers	_____ <i>ing</i> verb ending
_____ Location	_____ Asks Yes/No questions	_____ Possessive markers	_____ past tense verbs
_____ Temporal	_____ Follows simple directions	_____ Irregular plurals	_____ irregular past tense
_____ Sequence	_____ Follows complex directions	_____ Articles: the, a	_____ <i>is</i> as main verb
_____ Inclusion/exclusion	_____ Uses primarily simple phrases	_____ Prepositions: in, on	_____ <i>is</i> as helper
_____ Category names	_____ Full sentences, including verbs	_____ Pronouns-subjective	_____ 3 <sup>rd</sup> person singular -s
_____ Colors	_____ Uses complex sentences	_____ Pronouns-objective	
_____ Category items	_____ Uses inversion question form	_____ Pronouns-possessive	

**NARRATIVE SKILLS**

*(Ability to retell an event.)*

Type of narratives used:	_____ Personal narratives	_____ Retells stories/TV shows/procedure
Narratives told:	_____ With adult prompting	_____ Independently
Sequence of utterances:	_____ Utterances sequenced	_____ Utterances told in random order
Components included in narratives:	_____ People _____ outcomes	_____ Place (setting)

**PRAGMATICS**

*(Use of language in communicative interactions)*

_____ Used appropriate action – turn taking	_____ Varied language for different contexts	_____ Used appropriate eye contact
_____ Used appropriate verbal turn taking	_____ Maintained topics in conversation	_____ Initiated conversation
_____ Responded in conversation	_____ Revised speech when not understood	_____ Provided background information to listener

# V. FLUENCY

## DEFINITION/FLUENCY

“A fluency disorder is an interruption in the flow of speaking characterized by atypical rate, rhythm, and repetitions in sounds, syllables, words and phrases. This may be accompanied by excessive tension, struggle behavior, and secondary mannerisms,” which are markedly noticeable to the students or listener (ASHA, 1993, ¶3). Secondary characteristics may be presented by visible tension of the head, neck and shoulders. The physical characteristics such as eye blinks, wrinkling the forehead or sudden exhaustive exhaling, or verbal characteristics, such as word substitutions may also be present.

Feelings and attitudes should also be considered as an important component of non-fluent speech. Feelings are emotions such as fear and embarrassment that affect the attitudes of the stuttering student. Attitudes are based on prior experiences and may negatively affect the feelings of the stuttering student.

Stuttering may be viewed as a syndrome characterized by abnormal dysfluencies accompanied by observable affective, behavioral, and cognitive patterns (Cooper & Cooper, 1998).

## TYPES OF DYSFLUENCIES

The major dysfluency types are as follows:

- REPETITIONS
  - Characterized by part-word repetitions, whole-word repetitions, and phrase repetitions
  - Examples:
    - “What t-t-t time do I go?”
    - “Where-where-where are we going?”
    - “I had to-I had to-I had to find the letter.”
- HESITATIONS
  - A non-tense break in the forward flow of speech
  - Example:
    - “I \_\_\_\_\_ am here.”
- PROLONGATIONS
  - Characterized by sound/syllable prolongations, or silent prolongations.
  - Examples:
    - “I am s-s-s-so happy.”
    - A struggling attempt to say a word when there is no sound produced.

- INTERJECTIONS
  - Characterized by sound/syllable, whole-word and phrase use that are independent of context of utterance
  - **Examples:**
    - “um...um I forgot my homework today.”
    - “I forgot *well* my homework today.”
    - “I forgot *you know* my homework today.”
  
- SILENT PAUSES
  - Characterized by a silent duration within speech that is considered abnormal
  - Example:
    - “Let’s go to the \_\_\_\_\_store.”
  
- BLOCKAGES
  - Characterized by the tightening of muscles between words or parts of words, or audible abnormal breathing
  - Example:
    - “I *am* (forced breathing) going to work.”

# FLUENCY ELIGIBILITY/ENTRY CRITERIA

A student may meet eligibility criteria for services as a student who is speech/language impaired in the area of fluency when any of the following adversely effect educational performance:

- Student consistently exhibits one or more of the following symptomatic behaviors of dysfluency:
  - a) sound, syllable, or word repetition
  - b) hesitations
  - c) prolongations of sounds, syllables, or words
  - d) interjection
  - e) silent pause
  - f) blockages
  
- Student exhibits dysfluencies during connected speech in at least one of the following areas, with accompanying adverse effect on educational performance
  - a) Frequency measurements of dysfluencies yielding three or more stuttered words per minute based on a speech sample of 200 words (stuttered words per minute)
  - b) Frequency measurements of dysfluencies yielding 5 percent or greater stuttered words based on a speech sample of 200 words (percentage of stuttered words per sample)
  - c) The disruption occurs to the degree that the individual or persons who listen to the student react to the manner of speech and the disruptions in a way that impedes communication.

Adverse effects on educational performance include the following:

- Academic Performance
- Ability to benefit from the curriculum
- Examples: lower grades, difficulty with language based activities, comprehension, or oral communication
- Social Performance
- Ability to successfully interact with peers
- Examples: interference with listener understanding,
- Difficulty maintaining or terminating verbal interactions, experiencing teasing from peers, or demonstrating fear,
- Frustration, or embarrassment
- Vocational Performance
- Ability to participate in job-related activities
- Examples: following directions, exhibiting pragmatically
- Inappropriate behavior, asking or answering questions

## **Additional Considerations:**

Finding the line between normal dysfluency and fluency disorders can be quite difficult. Most normal dysfluencies are either repetitions of whole words, or pauses and interjections. But if a speaker repeats words quite frequently or repeats the same word again and again in the same utterance, his speech may be considered problematic. If his pauses are too frequent or too long, they may also be considered problematic. As listeners we are accustomed to hearing speech in a certain way, which lets us respond to the content of the message. But sometimes we find ourselves paying attention to how the speaker is talking instead. If we are paying attention to the dysfluencies in the speech, then the speaker may have crossed the line over to "disorder". Listener reactions are a significant dimension of a fluency disorder.

Fluency disorders are seen in both children and adults. The longer stuttering persists, the more likely it is that associated emotional problems will develop. As listeners react to a child developing stuttering speech, the child also reacts to his speech and to the reactions of others. He may feel embarrassed, guilty, frustrated, or angry. Many people who stutter come to feel helpless, which often damages their sense of personal value. Stuttering frequently leads to confusions and to social and emotional conflicts for the child or adult speaker, for his family, friends, teachers, and anyone else who interacts with him. Thus the normal dysfluency that is a relatively simple and effortless developmental milestone can be transformed into a serious social, emotional, and communicative handicap. It can profoundly affect an individual's self-concept, sense of worth, goals, aspirations, expectation, and basic style of coping with life.

## **RISK FACTORS FOR STUTTERING**

The SLP should consider the following risk factors:

1. Expansion of student's language structure beyond student's linguistic capacity
2. Deficits in language acquisition and usage (e.g., word retrieval)
3. Deficits in articulation
4. Learning disabilities
5. Learning English as a second language
6. Congenital or acquired neurological deficits
7. Family history of stuttering
8. Environmental pressure (e.g., over-scheduling)
9. High level of communicative demand
10. Medications

**Students are not eligible for services when exhibiting the following:**

- Dysfluencies are episodic or developmental.
- Dysfluencies do not interfere with educational performance
- Fluency patterns that are attributed only to dialectical, cultural, or ethnic differences or to the influence of a foreign language must not be identified as a disorder.
- Dysfluencies are produced effortlessly and with no tension, particularly at the beginning of an utterance.

## FLUENCY ASSESSMENT

Fluency is a speech pattern, which flows in a rhythmic, smooth manner. Dysfluencies are disruptions or breaks in the smooth flow of speech. Even speakers who are normally fluent experience dysfluencies. A speaker is dysfluent when unintentionally repeating a word or phrase, forgetting a word mid-utterance or interjecting too many “uhs” or “OK” during speech. It is the SLP’s responsibility to differentiate between normal dysfluencies and a fluency disorder (Shipley & McAfee, 1998).

### FLUENCY ASSESSMENT PROCEDURES:

- Collect data obtained during the pre-referral process
- Obtain classroom teacher input
- Obtain parent input
- Conduct a classroom observation (observe student in structured and unstructured situations in the school environment)
- Review student’s school records and/or reports from other agencies
- Interview student to determine self-perception of communication abilities
- Measure fluency using formal/informal assessments for frequency, descriptive assessment, self-awareness, and effect on educational performance
- Complete the *Fluency Severity Rating Scale* using the data from fluency assessment

Following are measurement considerations that will assist the SLP with the diagnosis of a fluency disorder:

### Fluency Measurement Considerations:

- frequency of stuttering (stuttered words per minute or percentage of stuttered words – this information can be gathered from formal/informal assessments)
- descriptive assessments (includes types of dysfluencies and secondary characteristics – this information can be gathered from classroom observations and assessments performed)
- self-awareness (coping mechanisms, covert stuttering behaviors)
- this information can be gathered from appropriate checklists)
- effect on educational performance (information gathered from teacher/parent input)

To analyze **frequency of stuttering**, use the following procedures:

- Collect and transcribe a spontaneous communication sample with a minimum of 200 words in a variety of settings, using audio or videotape. Do not count repetitions as words. Revisions are counted as part of the 200-word sample. The transcription should also include the instances of stuttering.

- Count the number of occurrences of dysfluencies such as hesitations, interjections, revisions, prolongations, visible/audible tension, etc. Count the number of instances of each type of stuttering and struggle behavior (audible/visible tension). Divide this number by the total number of words (200), and multiply by 100 to obtain the percentage of types of dysfluencies (Riley, 1980).
- To calculate the number of stuttered words per minute, you would simply need to take the number of stuttered words divided by the total time spoken by the student.
- *Note:* A frequency analysis may also be accomplished through the use of formalized assessments such as *Stuttering Severity Instrument* (Riley, 2008), *Monterey Fluency Program* (Ryan & Van Kirk, 1978), or *Cooper Personalized Fluency Control Therapy* (3<sup>rd</sup> ed.; Cooper & Cooper, 2004). When using these assessments be sure to adhere to the assessment procedures as specified in the testing manuals.

To analyze the **descriptive assessments**, which includes the types of dysfluencies and secondary characteristics, use the following procedures:

- Collect and transcribe a spontaneous communication sample with a minimum of 200 words in a variety of settings, using audio or videotape.
- Utilize the Fluency Charting Grid along with the Calculating the Dysfluency Index or the Frequency Count for Dysfluencies to indicate the type of dysfluency present.
- Utilize the classroom observation, teacher input, parent input and/or formal assessments to determine if secondary characteristics are present.

To analyze the **self-awareness**, which includes coping mechanisms and/or covert stuttering behaviors, use the following procedures:

- *Coping Mechanisms*-Culatta and Goldberg (1995) recommend using the following methods:
  - observations, checklists, rating scales and self-rating protocols
  - reports by the student of how he/she manipulates speech in order to cope with stuttering
  - reports by the student of experiences of tension
  - reports by the student of vigilance necessary to achieve and maintain fluent speech

*Covert Stuttering Behaviors*- Culatta and Goldberg (1995) recommend using a variety of interview and questionnaire protocols.

There are six major measurable types of covert stuttering behaviors:

- emotional reactions
- expectation of stuttering
- motivation
- avoidance
- expectation of fluency
- self-perception

All types are related to the stutterer's belief system and none are observable. To quantify them, diagnosticians must rely on the stutterer's self-assessment. This lack of verifiable data is viewed by some as introducing an unnecessary amount of subjectivity into the study of stuttering (Ingham, 1990). Others believe that even though measuring covert behaviors is not as easily accomplished or objective as overt behaviors, understanding the stutterer's belief system is essential for understanding how to proceed in therapy (Perkins, 1990; Cooper & Cooper, 1985).

Emotional Reaction – Each stutterer's reaction to both fluent and dysfluent speech is unpredictable. The fear of fluency may be as great as the fear of stuttering. Students may become withdrawn, aggressive, passive, hostile or depressed by their manner of speech. Speech-Language Pathologists (SLPs) need a window into these feelings to help construct an effective therapy plan.

Avoidance – Stutterers may not only tend to avoid production of feared sounds or words, but also situations and encounters with specific people. Regardless of the type of therapy in which the stutterer is involved, clinicians will almost always ask the stutterer to engage in feared situations. By having an understanding of what is currently being avoided, Speech-Language Pathologists can design a program that can eventually confront these avoidances.

Expectation of Stuttering – To a large extent, we are a product of our past experiences. Stutterers who expect to stutter may be engaging in a self-defeating exercise regardless of the therapeutic techniques taught to them by their SLP. By understanding the extent to which a stutterer believes that control and normal communication are impossible, Speech-Language Pathologists can begin addressing the problem.

Expectation of Fluency – It is important to determine if the stutterer believes that some form of control over speech is possible. The expectation that one can be fluent is an indication that the use of fluent speech is a possibility for that person.

Motivation – Changes in long-term behaviors can be difficult to accomplish, whether they involve behaviors such as smoking, procrastination or stuttering. Assessments of motivation are less likely to involve general questions of whether the individual would like to develop fluency and more likely to examine the extent of commitment and effort an individual is willing to make to affect behavioral change.

Self-Perception – How an individual sees himself/herself is important in the structuring of intervention goals and objectives. Consequently, different instructional protocols may be developed for two individuals who have similar covert behaviors but who differ dramatically on the degree of severity each perceives.

## **Measurement Procedures**

The two most common ways to obtain information about how a stutterer's beliefs can affect speech are the interview and use of the questionnaires. Questionnaires may require either forced-choice answers or rating scale evaluations. Examples of forced-choice questions are ones that can be answered with "yes" or "no", or those that require the stutterer to choose between self-descriptive statements, such as "a mild stutterer" or "a severe stutterer". A rating question asks the stutterer to describe his/her perceptions through the use of a scale with end points such as "calm" and "anxious", "mild" and "severe", or "strongly agree" and "strongly disagree". It is important to realize that the answers derived from these test instruments do not necessarily provide a picture of reality, but rather describe how stutterer view themselves within their world.

## **FLUENCY DISMISSAL/EXIT CRITERIA**

The criteria for exit from services for speech & language impairments should be discussed with IEP team members at the beginning of intervention.

A STUDENT WILL BE RECOMMENDED FOR DISMISSAL WHEN ANY OF THE FOLLOWING OCCUR:

1. The fluency goals as designated on the IEP have been achieved, and specially designed instruction is no longer warranted.
2. The student perceives himself/herself to be a normal speaker.
3. The fluency disorder no longer interferes with the student's ability to perform in the educational setting.
4. The fluency disorder no longer interferes with the student's ability to establish and maintain appropriate social/emotional development.
5. The student demonstrates a lack of motivation, consistent incompleteness of assignments or inappropriate behaviors that are not being cooperative, chronic absenteeism, or verbally or physically disrupts the therapy session. Attendance records and pertinent observations must be included in the documentation that indicate a variety of learning styles, service delivery models, and motivators were utilized to address the student's behavior and performance.
6. Withdrawal is requested by the parent/guardian. This must be obtained in writing and agreed upon by the educational team.

## V. FORMS/INSTRUCTIONS

Following are rating scales and input forms that will assist the SLP with the diagnosis of a fluency disorder:

- Fluency Severity Rating Scale instructions
- Fluency Severity Rating Scale
- Classroom Observation Form
- Teacher Input – Fluency
- Teacher Checklist - Fluency
- Parent Input – Fluency
- Student Interview Forms
  - Stutterer's Self-Rating of Reactions to Speech Situations
  - Perceptions of Stuttering Inventory (PSI)
  - Stuttering Problem Profile (SPP)
  - Stuttering Attitudes Checklist
  - Modified S-Scale
- Fluency Charting Grid
- Calculating the Dysfluency Index

## Fluency Severity Rating Scale Instructions

1. Determine frequency of stuttering by administering a commercial stuttering severity instrument or by collecting a spontaneous communication sample and analyzing according to frequency of stuttered words.
2. Utilize information obtained from a commercial stuttering severity instrument and/or spontaneous communication sample, Fluency Charting Grid, classroom observation, teacher/parent input to describe types of dysfluencies and secondary characteristics.
3. To determine student's self-awareness/perception of his/her fluency disorder, utilize information obtained from the various student checklists and rating scales.
4. To determine the effect of the fluency disorder on the student's educational performance, utilize information obtained during classroom observations, teacher/parent input.
5. Add the scores on the **rating scale** & circle the total.
6. Answer yes/no to the final statements at the bottom of the form.

**Criteria:** The total score must fall at least within the mild range and the score for "effect on educational performance" must be at least "4" to support a recommendation of eligibility.

Student: \_\_\_\_\_  
 School: \_\_\_\_\_

Date: \_\_\_\_\_  
 SLP: \_\_\_\_\_

**FLUENCY SEVERITY RATING SCALE**

	0	2	3	4
Formal/Informal Assessment Frequency of Stuttering	Frequency of dysfluency is within normal limits for age, sex and speaking situation and/or $\leq 2$ stuttered words per minute and or $\leq 4\%$ stuttered words	Occasional dysfluencies are observed in speaking situations and/or 3-4 stuttered words per minute and/or 5% to 11% stuttered words	Frequent dysfluencies are observed in many speaking situations and/or 5-9 stuttered words per minute and/or 12% to 22% stuttered words	Dysfluencies are observed in majority of speaking situations and/or More than 9 stuttered words per minute and/or $> 23\%$ stuttered words
Descriptive Assessments	Speech flow is within normal limits Developmental dysfluencies may be present No secondary characteristics are observed	Fluent speech periods predominate One or more major dysfluency types are present No secondary characteristics are present	One or more major dysfluency types are present Secondary characteristics, including blocking, avoidance, and physical concomitants may be observed	Dysfluent speech predominates One or more major dysfluency types are present Secondary characteristics predominate. Avoidance, frustration and struggle behaviors are observed
Self-Awareness	Little overt reaction and apparently no self-concept as a stutter	May or may not be aware. Typically no particular reactions are observed.	Typically aware and demonstrates reactions. May or may not demonstrate avoidance.	Awareness may result in extreme reactions and avoidance of most speaking situations.
	0	4	6	8
Effect on Educational Performance. Social Emotional Academic Vocational	No interference with child's participation in educational setting. Acquisition of basic cognitive and/or affective performance skills is not affected.	Minimal impact on the child's participation in educational setting. Acquisition of basic cognitive and/or affective performance skills may be affected.	Does interfere with child's participation in educational setting. Acquisition of basic cognitive and/or affective performance skills is usually affected.	Seriously limits child's participation in educational setting. Acquisition of basic cognitive and/or affective performance skills is impaired.
<b>Total Score</b>	<b>0 2 3 4 5</b>	<b>6 7 8 9 10</b>	<b>11 12 13 14 15</b>	<b>16 17 18 19 20</b>
<b>Rating Scales</b>	<b>Normal / Adequate</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>

Yes  No

Based on compilation of the assessment data, this student scores in the Mild, Moderate or Severe range for a Fluency Disorder

Yes  No

There is documentation/supporting evidence of adverse effects of the Fluency Disorder on educational performance.

## Classroom Observation Form

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Class: \_\_\_\_\_

Observer: \_\_\_\_\_

### PRIOR TO OBSERVATION

#### Review Records:

##### Teacher Concerns

#### Student Preparation for/Attention to Instruction:

Yes No Sometimes N/A

- Is prepared for class
- Materials/desk appear organized
- Homework is completed
- Body language indicates positive attitude
- Appears to pay attention
  - In large group
  - In small group
  - In one-on-one
- Stays in seat or work area
- Takes notes
- Follows along in text
- Participates in discussions
- Attends to auditory/visual/multimodality instruction
- Follows two or more speakers
- Remain on-task during observational period

#### Student Response to Instructional Style:

- Asks questions for clarification
- Requests assistance from teacher/peers
- Asks for repetition of instructions
- Answers oral questions with appropriate/related response
- Responds to written instruction
- Looks to others for clues
- Requires additional response time
- Works without reinforcement
- Responds to concrete/verbal reinforcement

#### Student Behavior:

- Follows classroom rules & routine
- Works independently
- Accepts errors/constructive criticism
- Appears accepted by peers
- Seems to like other students

**Student Behavior: (Continued)**

**Yes No Sometimes N/A**

Seems aware of speech/language difficulties  
Uses free time constructively

**Student's Communicative Proficiency:**

**Articulation/Phonology**

Makes sound errors (list sound errors/phonological processes  
you observe child using: \_\_\_\_\_)  
Uses dialectal pattern other than Standard English  
Has difficulty sequencing sounds in multisyllabic words  
Intelligibly interferes with communication

**Voice**

Rate is too fast or too slow  
Voice quality is harsh, breathy, nasal, hoarse  
Voice is intermittently or completely lost  
Pitch is too high or too low  
Volume is too loud or too soft

**Fluency**

Fluency is interrupted by repetitions  
Fluency is interrupted by prolongations or injections  
Fluency is interrupted by secondary characteristics  
Speech causes student frustration  
Speech pattern seems to interfere with communication  
Student hesitates to speak in class  
Others comment on student's speech

**Language**

Maintains eye contact when speaking  
Speaks in complete sentences  
Uses correct question form  
Uses subject-verb agreement  
Uses pronouns correctly  
Uses negation  
Uses plural forms correctly  
Uses appropriate verb tense  
Uses complex sentences  
Uses precise vocabulary  
Appears to have adequate vocabulary  
No apparent word retrieval difficulties  
Relates stories in correct sequence  
Responds correctly to general comprehension questions  
Responds correctly to comprehension questions about specific oral instruction  
Responds correctly to comprehension questions about written passage  
Comprehends concepts of time, space, quantity, quality and directionality



## Teacher Input – Fluency

Student \_\_\_\_\_ School \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

*Your observation of the above student's language will help determine if a language problem adversely affects educational performance. (Note: Educational performance refers to the student's ability to participate in the educational process and must include consideration of the student's social, emotional, academic and vocational performance.) Check all age-appropriate items that have been observed.*

Please return the completed form to the speech/language therapist by \_\_\_\_\_ (date)

**Compared to other students in the classroom.....**

	<i>Not appropriate</i>	<b>Yes</b>	<b>No</b>	<b>Sometimes</b>
• Does this student have a reduced verbal output?				
▪ Does this student appear to avoid talking in class?				
▪ Do you feel this student is delayed in language skills?				
▪ Does this student use significantly more one-word responses (ex. twice as many) than the other students in your class?				
▪ Does this student appear to dislike reading out loud?				
▪ Does this student correct or revise his/her spoken errors less often than the other students in your class revise their spoken errors?				
▪ Do you think this student knows he/she is having problems when he speaks?				
▪ Has this student ever talked to you about his/her speech problem?				
▪ Has either of the student's parents talked to you about his/her fluency problems?				
▪ Do classmates make fun of this student because of his/her fluency problems?				
▪ Have you heard anyone call him/her a stutterer?				
▪ Does this student's speech problem make it difficult to understand the content of his/her speech?				
▪ Does this student's fluency problem distract you sometimes from he/she is saying?				

**Circle the types of dysfluencies observed in the classroom:**

**Repetitions:** Sound (g-g-go) Syllable (af-af-after) Word (I-I-I am) Phrase (He went-he went-he went home)

**Prolongations:** (ssssit down) (goooo away)

**Blocks or hesitations** ( \_\_\_\_\_ don't do that) (Where is \_\_\_\_\_ my cookie)

**It is my opinion that these behaviors \_\_\_\_\_do/ \_\_\_\_\_do not adversely affect the student's educational performance.**



Fayette-Greene-Washington

## TEACHER CHECKLIST - FLUENCY

STUDENT: _____	BIRTHDATE: _____	C.A.: _____	GRADE: _____
SCHOOL: _____	TEACHER: _____	DATE: _____	
SPEECH/LANGUAGE PATHOLOGIST: _____			

The child above has been referred for or is receiving services regarding fluency skills. Please help me gain a better overall view of this student's speech skills by completing the following information:

### Informational Checklists:

- This student: (Check all that apply)
  - Doesn't mind talking in class.
  - Seems to avoid speaking in class. (Does not volunteer, if called upon, may frequently not reply)
  - Speaks with little or no outward signs of frustration.
  - Is difficult to understand in class.
  - Demonstrates frustration when speaking (please describe): \_\_\_\_\_
  - Performs average or above average academically.
  
- This student is dysfluent or stutters when he/she: (Check all that apply)
  - Begins the first word or a sentence.
  - Speaks to the class.
  - Speaks during an entire sentence.
  - Gets upset.
  - Uses little words.
  - Shares ideas or tells a story.
  - Uses main words.
  - Answers questions.
  - Talks with peers.
  - Carries on a conversation.
  - Gives messages.
  - Reads aloud.
  - Talks to adults.
  - Other \_\_\_\_\_
  
- Check any of the following behaviors you have noticed in this child's speech:
  - Revisions (starting and stopping and starting over again)
  - Frequent interjections (um, like, you know)
  - Word repetitions (we-we-we)
  - Phrase repetitions (and then, and then)
  - Part-word repetitions (ta-ta-take)
  - Sound repetitions (t-t-t take)
  - Prolongations (n-----obody)
  - Block (noticeable tension/no speech comes out)

- \_\_\_\_\_ Unusual face or body movements (visible tension, head nods, eye movements)
- \_\_\_\_\_ Abnormal breathing patterns
- \_\_\_\_\_ Other \_\_\_\_\_

**In the Classroom:**

1. I do/do not have concerns about this child's speech because:
  2. I observe the most disfluency when:
  3. When this child has difficulty speaking he/she reacts by:
  4. When this child has difficulty speaking, I respond by:
1. I do/do not have concerns about this child's speech because:
  2. I observe the most disfluency when:
  3. When this child has difficulty speaking he/she reacts by:
  4. When this child has difficulty speaking, I respond by:

**Your Perceptions:**

1. I have/have not had prior experience with a child who stutters.
2. I feel stuttering is caused by:
3. Some questions I have about stuttering are:
4. Some questions I have about helping this child be successful in the classroom would be:
5. The amount of knowledge I currently have regarding the disorder of stuttering is:  
 Nothing A Lot  
 1            2            3            4            5            6            7
6. My confidence level regarding dealing with stuttering in the classroom would be:  
 No Confidence Very Confident  
 1            2            3            4            5            6            7
7. My comfort level when communicating with this child is:  
 Uncomfortable Very Comfortable  
 1            2            3            4            5            6            7

**Your Observations:**

This child with PEERS:

1. Please describe this child's relationships with others of the same age.

2. Has this student been teased or mimicked because of his/her speech?
3. When this child has difficulty speaking, the other children react by:
4. Following a reaction by a peer, this child:

This child in GENERAL:

1. Have other students or this student's parent(s) ever mention his/her fluency problems?  
If yes, what was discussed?
2. Has this student ever talked to you about his/her speech problem? If yes, what was discussed?
3. What other information might be pertinent regarding this child's speech and language skills?
4. Do you have any other concerns regarding this child's speech and language, academic, or social skills?

Thank you for taking time to share this helpful information.

Please return this form to \_\_\_\_\_ by \_\_\_\_\_  
Speech/Language Pathologist Date

***Note: Because follow-up is so important, I would like to observe this child in at least three different speaking situations. Please list some times that this student:***

***Goes to lunch \_\_\_\_\_***

***Has the most opportunity to share in the classroom \_\_\_\_\_***

***Attends gym class \_\_\_\_\_***

## Parent Input – Fluency Intermediate Unit 1

Student: \_\_\_\_\_ Date: \_\_\_\_\_  
Teacher: \_\_\_\_\_  
Grade/Program: \_\_\_\_\_

Please return the completed form to the speech-language pathologist by

\_\_\_\_\_

Please complete all of the following questions relating to your child's speech. Your observations and responses concerning your child will help determine if there is a significant problem with fluency that adversely impacts educational performance. (Note: Educational performance refers to the student's ability to participate in the educational process and must include consideration of the student's social, emotional, academic and vocational performance).

1. Give approximate or exact date when stuttering was first noticed. \_\_\_\_\_
2. Who noticed the stuttering first? \_\_\_\_\_
3. In what situation was it first noticed or commented upon? Under what circumstances did it occur?

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4. At the time when stuttering was first noticed, did the student seem to be aware of the fact he/she was speaking in a different manner? **YES** **NO**
5. Did he/she ever show surprise or bewilderment after having trouble on a word? If so, how did he/she show such reactions?

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6. Was there an awareness of stuttering by the student in any way at first? If so, amplify your answer. After having a lot of trouble on a word, were any of the following observed? (Circle those that apply)

- a. Suddenly stopped trying? \_\_\_\_\_
- b. Suddenly left the speaking situation? \_\_\_\_\_
- c. Shouted the word? Cried? Hit someone? Smashed something? Spit on somebody? Hid his/her face? Laughed? Did something else?  
\_\_\_\_\_

d. Seemed to be a little more careful with his/her speech in attempting words on which she/he had difficulty? How? By lowering voice? By slowing down? By ceasing other bodily activity for the moment? By looking straight ahead for the moment? By shifting gaze away from the listener? Any other way?  
\_\_\_\_\_

7. \_\_\_\_\_ What attempts have been made to correct stuttering? \_\_\_\_\_

8. At the time when stuttering was first noticed, was there more trouble exhibited in some situations than in others? If so, what were they? \_\_\_\_\_

9. Did stuttering occur more often when speaking with certain people? Who? \_\_\_\_\_

10. Were there any topics of conversation with which he/she had more trouble? If so, what? \_\_\_\_\_

11. Did excitement seem to cause more stuttering? \_\_\_\_\_

12. Did he/she talk to strangers with less trouble than to people he/she knew well? \_\_\_\_\_

13. At the time when stuttering began, did fatigue, fear, illness, or pressing need for communication seem to cause more trouble? \_\_\_\_\_

14. Since stuttering first began, has there been any change in the stuttering symptoms? If so, describe: \_\_\_\_\_  
\_\_\_\_\_

15. Did you notice a gradual increase in stuttering?           **YES**           **NO**

16. Were there any instances in which the number of troublesome words and number of repetitions suddenly increased?           **YES**           **NO**  
\_\_\_\_\_  
\_\_\_\_\_

17. Rate the impact of your child's fluency on his/her social, emotional, academic and/or vocational functioning. Circle one:

does not interfere

minimal impact

interferes

seriously limits

**STUTTERER'S SELF-RATING OF REACTIONS TO SPEECH SITUATIONS**

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Examiner \_\_\_\_\_ Date \_\_\_\_\_

After each item put a number from 1 to 5 in each of the four columns.

Start with right-hand column headed *Frequency*. Study the five possible answers to be made in responding to each item and write the number of the answer that best fits the situation for you in each case. Thus, if you habitually take your meals at home and seldom eat in a restaurant, certainly not as often as once a week; write the number 5 in the *Frequency* column opposite item No. 1, "Ordering in a restaurant." In like manner respond to each of the other 39 items by writing the most appropriate number in the *Frequency* column. When you have finished with this column fold it under so you cannot see the numbers you have written. This is done to keep you from being influenced unduly by the numbers you have written in the *Frequency* column when you write your responses to the 40 situations in the Stuttering column.

Now, write the number of the response that best indicates how much you stutter in each situation. For example, if in ordering meals in a restaurant you stutter mildly (for you), write the number 2 in the *Stuttering* column after item No. 1. In like manner respond to the other 39 items. Then fold under the *Stuttering* column so you will not be able to see the numbers you have written in it when you make your responses in the *Reaction* column.

Following the same procedure, write your responses in the *Reaction* column, fold it under. And, finally write your responses in the *Avoidance* column.

Number for each of the columns are to be interpreted as follows:

A. Avoidance

1. I never try to avoid this situation and have no desire to avoid it.
2. I don't try to avoid this situation, but sometimes I would like to.
3. More often than not I do not try to avoid this situation, but sometimes I do try to avoid it.
4. More often than not I do try to avoid this situation.
5. I avoid this situation every time I possibly can.

B. Reaction

1. I definitely enjoy speaking in this situation.
2. I would rather speak in this situation than not.
3. It's hard to say whether I'd rather speak in this situation or not.
4. I would rather not speak in this situation.
5. I very much dislike speaking in this situation.

C. Stuttering

1. I don't stutter at all (or only very rarely) in this situation.
2. I stutter mildly (for me) in this situation.
3. I stutter with average severity (for me) in this situation.
4. I stutter more than average (for me) in this situation.
5. I stutter severely (for me) in this situation.

D. Frequency

1. This is a situation I meet very often, two or three times a day, or even more, on the average.
2. I meet this situation at least once a day with rare exceptions (except Sunday, perhaps).
3. I meet this situation from three to five times a week on the average.
4. I meet this situation once a week, with few exceptions, and occasionally I meet it twice a week.
5. I rarely meet this situation-certainly not as often as once a week.

	Avoidance	Reaction	Stuttering	Frequency
1. Ordering in a restaurant				
2. Introducing myself (face to face)				
3. Telephoning to ask price, train fare, etc.				
4. Buying plane, train or bus ticket.				
5. Short class recitation (ten words or less)				
6. Telephoning for taxi				
7. Introducing one person to another				
8. Buying something form store clerk				
9. Conversation with good friend				
10. Talking with an instructor after class or in his/her office				
11. Long distance telephone call to someone I know				
12. Conversation with my father				
13. Asking girl for date (or talking to man who asks me for a date)				
14. Making short speech (one or two minutes) in familiar class				
15. Giving my name over the telephone				
16. Conversation with my mother				
17. Asking a secretary if I can see his/her employer				
18. Going to house and asking for someone				
19. Making a speech to unfamiliar audience				
20. Participating in committee meeting				
21. Asking instructor question in class				
22. Saying hello to a friend going by				
23. Asking for a job				
24. Telling a person a message form someone else				
25. Telling a funny story with one stranger in a crowd				
26. Parlor games requiring speech				
27. Reading aloud to friends				
28. Participating in a bull session				
29. Dinner conversation with strangers				
30. Talking with my barber (or beauty operator)				
31. Telephoning to make appointment or arrange meeting place with someone				
32. Answering roll call in class				
33. Asking at a desk for a book or card to be filled out				
34. Talking with someone I don't know well while waiting for bus or class, etc.				
35. Talking with other players during a game				
36. Taking leave of a hostess				
37. Conversation with a friend walking along the street				
38. Buying stamps at post office				
39. Giving directions or information to strangers				
40. Taking leave of a girl /boy after a date				
TOTAL				
Average				
Number of 1's				
Number of 2's				
Number of 3's				
Number of 4's				
Number of 5's				

## PERCEPTIONS OF STUTTERING INVENTORY (PSI)

Name \_\_\_\_\_ Age \_\_\_\_\_ S \_\_\_\_\_ A \_\_\_\_\_ E \_\_\_\_\_

Examiner \_\_\_\_\_ Date \_\_\_\_\_

### Directions

Here are sixty statements about stuttering. Some of these may be characteristic of your stuttering. Read each item carefully and respond as in the example below.

#### Characteristic of me

\_\_\_\_\_ Repeating sounds.

Put a check mark (✓) under characteristic of me if “repeated sounds” is part of your stuttering; if it is not characteristic, leave the space blank.

Characteristic of me refers only to what you do now, not to what was true of your stuttering in the past and which you no longer do, and not what you think you should or should not be doing. Even if the behavior described occurs only occasionally or only in some speaking situations, if you regard it as characteristic of your stuttering, check the space under characteristic of me.

#### Characteristic of me

1. \_\_\_\_\_ Avoiding talking to people in authority (e.g., teacher, employer, or clergyman) (A)
2. \_\_\_\_\_ Feeling that interruptions in your speech (e.g., pauses, hesitations, or repetitions) will lead to stuttering. (E)
3. \_\_\_\_\_ Making the pitch of your voice higher or lower when you expect to get “stuck” on words. (E)
4. \_\_\_\_\_ Having extra and unnecessary facial movements (e.g., flaring your nostrils during speech attempts). (S)
5. \_\_\_\_\_ Using gestures as a substitute for speaking (e.g., nodding your head instead of saying “yes” or smiling to acknowledge a greeting). (A)
6. \_\_\_\_\_ Avoiding asking for information (e.g., asking for directions or inquiring about a train schedule). (A)
7. \_\_\_\_\_ Whispering words to yourself before saying them or practicing what you are planning to say long before you speak. (E)
8. \_\_\_\_\_ Choosing a job or a hobby because little speaking would be required. (A)
9. \_\_\_\_\_ Adding an extra and unnecessary sound, word or phrase to your speech (e.g., “uh”, “well”, or “let me see”) to help yourself get started. (F)
10. \_\_\_\_\_ Replying briefly using the fewest words possible. (A)
11. \_\_\_\_\_ Making sudden jerky or forceful movements with your head, arms or body during speech attempts (e.g., clenching your fist or jerking your head to one side) (S)
12. \_\_\_\_\_ Repeating a sound or word with effort. (S)
13. \_\_\_\_\_ Acting a manner intended to keep you out of a conversation or discussion (e.g., being a good listener, pretending not to hear what was said, acting bored or pretending to be in deep thought. (A)

14. \_\_\_ Avoiding making a purchase (e.g., going into a store or buying stamps in the post office) (A)
15. \_\_\_ Breathing noisily or with great effort while trying to speak. (S)
16. \_\_\_ Making your voice louder or softer when stuttering is expected. (E)
17. \_\_\_ Prolonging a sound or word (e.g. m-m-m-m-my) while trying to push it out. (S)
18. \_\_\_ Helping yourself to get started talking by laughing, coughing, clearing your throat, gesturing or some other body activity or movement. (E)
19. \_\_\_ Having general body tension during speech attempts (e.g., shaking, trembling or feeling knotted up inside). (S)
20. \_\_\_ Paying particular attention to what you are going to say (e.g., the length of a word or the position of a word in a sentence). (E)
21. \_\_\_ Feeling your face getting warm and red (as if you are blushing) as you are struggling to speak. (S)
22. \_\_\_ Saying words or phrases with force or effort. (S)
23. \_\_\_ Repeating a word or phrase preceding the word on which stuttering is expected. (E)
24. \_\_\_ Speaking so that no word or sound stands out (e.g., speaking in a singsong voice or in a monotone). (E)
25. \_\_\_ Avoiding making new acquaintances (e.g., not visiting with friends, not dating, or not joining social, civic, or church groups). (A)
26. \_\_\_ Making unusual noises with your teeth during speech attempts (e.g., grinding or clicking your teeth) (S)
27. \_\_\_ Avoiding introducing yourself, giving your name, or making introductions. (A)
28. \_\_\_ Expecting that certain sounds, letters or words are going to be particularly "hard" to say (e.g., words beginning with the letter "p") (E)
29. \_\_\_ Giving excuses to avoid talking (e.g., pretending to be tired or pretending lack of interest in a topic). (A)
30. \_\_\_ Running out of "breath" while speaking. (S)
31. \_\_\_ Forcing out sounds. (S)
32. \_\_\_ Feeling that your fluent periods are unusual, that they cannot last, and that sooner or later you will stutter. (E)
33. \_\_\_ Concentrating on relaxing or not being tense before speaking. (E)
34. \_\_\_ Substituting a different word or phrase for the one you had intended to say. (A)
35. \_\_\_ Prolonging or emphasizing the sound preceding the one on which stuttering is expected. (E)
36. \_\_\_ Avoiding speaking before an audience. (A)
37. \_\_\_ Straining to talk without being able to make a sound. (S)
38. \_\_\_ Coordinating or timing your speech with a rhythmic movement (e.g., lapping your feet or swinging your arm).
39. \_\_\_ Rearranging what you had planned to say to avoid a "hard" sound or word. (A)
40. \_\_\_ "Putting on an act" when speaking (e.g., adopting an attitude of confidence or pretending to be angry). (E)
41. \_\_\_ Avoiding the use of the telephone. (A)
42. \_\_\_ Making forceful and strained movements with your lips, tongue, jaw or throat (e.g., moving your jaw in an uncoordinated manner). (S)
43. \_\_\_ Omitting a word, part of a word or a phrase which you had planned to say (e.g., words with certain sounds or letters). (A)
44. \_\_\_ Making "uncontrollable" sounds while struggling to say a word. (S)

45. \_\_\_\_ Adopting a foreign accent, assuming a regional dialect, or imitating another person's speech. (E)
46. \_\_\_\_ Perspiring much more than unusual while speaking (e.g., feeling the palms of your hands getting clammy). (S)
47. \_\_\_\_ Postponing speaking for a short time until certain you can be fluent (e.g., pausing before "hard" words). (E)
48. \_\_\_\_ Having extra and unnecessary eye movements while speaking (e.g., blinking your eyes or shutting your eyes tightly) (S)
49. \_\_\_\_ Breathing forcefully while struggling to speak. (S)
50. \_\_\_\_ Avoiding talking to others of your own age group (your own or the opposite sex). (A)
51. \_\_\_\_ Giving up the speech attempt completely after getting "stuck" or if stuttering is anticipated. (A)
52. \_\_\_\_ Straining the muscles of your chest or abdomen during speech attempts. (S)
53. \_\_\_\_ Wondering whether you will stutter or how you will speak if you do stutter. (E)
54. \_\_\_\_ Holding your lips, tongue, or jaw in a rigid position before speaking or when getting "stuck" on a word. (S)
55. \_\_\_\_ Avoiding talking to one or both of your parents. (A)
56. \_\_\_\_ Having another person speak for you in a difficult situation (e.g., having someone make a telephone call for you or order for you in a restaurant). (A)
57. \_\_\_\_ Holding your breath before speaking. (S)
58. \_\_\_\_ Saying words slowly or rapidly preceding the word on which stuttering is expected. (E)
59. \_\_\_\_ Concentrating on how you are going to speak (e.g., thinking about where to put your tongue or how to breathe). (E)
60. \_\_\_\_ Using your stuttering as the reason to avoid a speaking activity. (A)

## STUTTERING PROBLEM PROFILE (SPP)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

School: \_\_\_\_\_

**Instruction:** On the following pages is a list of statements made by stutterers about their stuttering problem following a period of therapy. In order to help you and your Speech/Language Therapist to define goals for intervention, please circle the number of those statements that you would like to be able to make at the termination of therapy that you don't feel you can make now. If there are statements you would like to be able to make that aren't included in the list, write them on the last page.

1. I am usually willing to stutter openly.
2. I have learned to speak on exhalation rather than on inhalation.
3. I don't usually have trouble with the first sounds of words.
4. I no longer have a great deal of difficulty speaking in school.
5. I am able to give myself assignments and carry them out to my own satisfaction.
6. I am usually willing to use the telephone.
7. I am as cheerful as most people.
8. I don't usually experience a great amount of tension and feeling of panic before speaking engagements.
9. I repeat sounds, syllables and words infrequently.
10. I have a strong desire to do something about my stuttering problem.
11. I used to be quiet and shy. Now I tend to be outgoing.
12. My attitude toward my stuttering is no longer one of embarrassment.
13. I am not in a rush to respond when talking with people.
14. I don't usually experience emotional depression after stuttering in front of other people.
15. I can usually control the level of tensing when involved in speaking situations.
16. I can read relatively fluently.
17. I have learned to live with my problem.
18. I have learned not to be afraid of people.
19. I no longer have the feeling that stuttering is a miserable abnormality.
20. I am putting more emphasis on communication than on words.
21. I have learned how to stutter in a way that is more acceptable to the listener.
22. I have gained a better overall understanding of the problem.
23. I am confident that if I work at it, I can do something about my stuttering.
24. I understand how fluent speakers react to stutters and why.
25. I usually don't hold myself back from talking when with a group of people.
26. I am not as ashamed as I used to be because of my stuttering.
27. I usually don't stutter much when giving a formal report to a group of people.
28. I have gained increased courage to participate in conversations, answer phone calls and talk to strangers.
29. I am reasonably tolerant of nonfluency in general.
30. I usually don't avoid feared words and situations.
31. I no longer have a feeling of hopelessness about my stuttering and the fact that I am a stutterer.
32. My mental attitude toward my stuttering has changed.

33. My present attitude is “true acceptance” of the fact that I am a stutterer.
34. I talk as much as most people.
35. When around other people, I don't usually hold back my feelings because of fear or stuttering.
36. I usually am not preoccupied with myself.
37. I am usually willing to discuss my problem with other people.
38. I no longer object to my therapy program.
39. I have expanded my activities, both social and business.
40. I usually don't have strong feelings of shame and embarrassment when I block.
41. I now feel I could change what I do when I stutter if I would wake up and do it.
42. I no longer anticipate stuttering on certain sounds.
43. I am convinced that I can talk without having to struggle.
44. I don't usually become very anxious when I have to initiate a phone call.
45. My breathing while speaking usually isn't irregular.
46. When I stutter, related movements such as hand jerks and eye blinking rarely occur.
47. I no longer speak at an excessive rate.
48. I usually am not afraid of public reading.
49. I find it relatively easy to ask a clerk for something in a store.
50. I can purposely speak the way I want in the majority of situations.
51. I would be willing to become an office in a club where I would have to give speeches.
52. I have learned that speaking can be an enjoyable experience.
53. I don't usually worry about entering speaking situations.
54. I don't usually become extremely depressed when in a period of “regression” in my speech.
55. I no longer consider myself an oddity because I stutter.
56. I usually am willing to say what I feel like saying.
57. I usually am not afraid to stutter in front of people.
58. My self-confidence has increased considerably.
59. It doesn't bother me to hear other stutters speak.
60. I try to avoid changing words I think I will stutter on.
61. Words that I used to use as “starters” have all but completely disappeared.
62. I am getting involved in many speaking situations.
63. I believe I can overcome my problem to the extent I can live comfortably with it.
64. I look upon my stuttering as something that can be changed or modified.
65. I have as many friends as most people.
66. I have learned to modify some of the overt behavior (e.g., facial grimaces).
67. I am relatively relaxed in speaking situations.
68. I am sure I can completely conquer the problem.
69. I recognize the worth of experimenting and playing around with my stuttering.
70. I don't usually experience feelings of failure when in a period of “regression” in my speech.
71. I no longer try to avoid looking at the person with whom I am talking while I am stuttering.
72. I now rarely anticipate stuttering.
73. I feel that I have learned to accept the fact I stutter.
74. I have quit being a lone wolf.
75. I do not react violently to my nonfluencies.
76. I feel fairly confident I can do something about my stuttering.
77. I have finally accepted the fact I am a stutterer. Before I never felt like I was one and always tried to “hide” it.
78. I push myself to enter situations in which I know I will stutter instead of avoiding them.
79. I probably talk to as many people as most persons.

80. I am usually willing to modify my stuttering blocks outside the therapy situation in the manner recommended by my therapist.
81. I usually don't worry very much about the reactions of others when I have a speech block.
82. I am paying more attention to my strengths than my weaknesses.
83. I tend to be relatively relaxed when giving a formal report to a group of people.
84. I usually am not afraid to approach people and talk to them.
85. I realize that improving my speech must be a day-to-day affair with specific goals and assignments set up.
86. I have accepted a certain amount of nonfluency as normal speech behavior.
87. I recite in the classroom as much as most students.

Additional Statements

## STUTTERING ATTITUDES CHECKLIST

**Agree or Disagree:** Put a plus (+) sign in front of the statements you agree with, a minus (-) sign in front of the statements you don't agree with. Make your decisions quickly. Even if you can't decide which answer is right for you, check the answer that seems to be closest to your feelings.

- I sometimes feel that my stuttering is my own fault
- My teachers should not make me answer questions in class if they think I will stutter when I answer.
- I think people who stutter should plan to take jobs that do not demand a lot of talking.
- I feel that it is best if I do not talk about my stuttering with my friends.
- People who stutter should not accept leadership jobs where they must give orders.
- It is wrong for my teachers to talk about the problems of stuttering to my classmates.
- People seem to make more fun of us who stutter than they do of people with other kinds of problems.
- I think my stuttering is one of my biggest problems.
- My stuttering is my biggest problem.
- Sometimes I think the best way to help someone who stutters is to do nothing or say nothing about it.
- I think if I could stop worrying about my stuttering, it would go away.
- Sometimes I feel I should be able to stop my stuttering on my own without help.
- I doubt if I will ever be able to talk without stuttering being a big problem for me.
- I think stuttering makes it harder for me to make friends.
- My stuttering has caused me to make poorer grades in school.
- Once in awhile I think I stutter on purpose to get people's attention.
- My stuttering was probably made worse by the way my parents reacted to it.
- I think it is best to have my parents or my friends order for me in restaurants so I will not embarrass them when I stutter.
- I think that most people who stutter are probably not quite as smart as people who do not stutter.
- I also think that most people who stutter probably have some kind of mental or emotional problems.
- Sometimes I think my parents may have caused my stuttering.
- I believe my parents think that they are the cause of my stuttering.
- I doubt if speech therapy can help me a whole lot.
- Maybe stuttering is "catching" and people might start stuttering if they are around me very much.
- My teachers make my stuttering worse.

## THE MODIFIED S-SCALE

**Instructions:** Answer the following by circling “T” if the statement is generally true for you, or circle “F” if the statement is generally false for you. If the situation is unfamiliar or rare, judge it on a “If it was familiar...” basis.<sup>1</sup>

1. T F I usually feel that I am making a favorable impression when I talk.
2. T F I find it easy to talk with almost anyone.
3. T F I find it very easy to look at my audience while talking in a group.
4. T F A person who is my teacher or my boss is hard to talk to.
5. T F Even the idea of giving a talk in public makes me afraid.
6. T F Some words are harder than others for me to say.
7. T F I forget all about myself shortly after I begin to give a speech.
8. T F I am a good mixer.
9. T F People sometimes seem uncomfortable when I am talking to them.
10. T F I dislike introducing one person to another.
11. T F I often ask questions in group discussions.
12. T F I find it easy to keep control of my voice when speaking.
13. T F I do not mind speaking before a group.
14. T F I do not talk well enough to do the kind of work I'd really like to do.
15. T F My speaking voice is rather pleasant and easy to listen to.
16. T F I am sometimes embarrassed by the way I talk.
17. T F I face most speaking situations with complete confidence.
18. T F There are few people I can talk with easily.
19. T F I talk better than I write.
20. T F I often feel nervous while talking.
21. T F I often find it hard to talk when I meet new people.
22. T F I feel pretty confident about my speaking abilities.
23. T F I wish I could say things as clearly as others do.
24. T F Even though I knew the right answer, I have often failed to give it because I was afraid to speak out.

---

<sup>1</sup> Note that items 4,5,6,9,10,14,16,18,20,21,23 and 24 are presumed to be true for people who stutter; the other items are presumed to be false.



## Calculating the Dysfluency Index

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Examiner: \_\_\_\_\_

**Instructions:** Transfer your findings from the “Fluency Charting Grid” to the appropriate blanks below to determine the total dysfluency index and/or the index for specific dysfluency types. Calculate dysfluency indexes for general or specific dysfluency types. For example, *Repetitions* are general fluency types which consist of specific types: *Part-word*, *Whole-word*, and *Phrase Repetitions*.

Environment: \_\_\_\_\_

Sample Type: \_\_\_\_\_

**Total Number of Words:** \_\_\_\_\_

	Number of Dysfluencies	Dysfluency Index
<b>Repetitions (R):</b>	_____	_____
Part-word (R-PW):	_____	_____
Whole-word (R-WW):	_____	_____
Phrase (R-P):	_____	_____
<b>Prolongations (P):</b>	_____	_____
Sound (P-Sd):	_____	_____
Silent (P-Si):	_____	_____
<b>Interjections (I):</b>	_____	_____
Sound/Syllable (I-SS):	_____	_____
Whole-word (I-Wd):	_____	_____
Phrase (I-Ph)	_____	_____
<b>Silent Pauses (SP):</b>	_____	_____
<b>Broken Words (BW):</b>	_____	_____
<b>Incomplete Phrases (Inc):</b>	_____	_____
<b>Revisions (Rev):</b>	_____	_____
<b>TOTAL NUMBER OF DYSFLUENCIES:</b>	_____	_____

**Comments:**

# VI. VOICE

## DEFINITION/VOICE

A voice disorder exists when the vocal characteristics of pitch, intensity, quality, or resonance interfere with communication, draw unfavorable attention, adversely affect the speaker or listener, and/or are inappropriate to the age and/or sex of the individual.

A voice disorder is characterized by the abnormal production and/or absence of vocal quality, pitch, loudness, resonance, or duration, which is inappropriate for an individual's age and/or sex"(ASHA, 1993, ¶3).

Voice disorders are classified according to their etiology or symptoms. The etiology is its cause, which is either organic or functional. Organic disorders have a known physical cause with a related medical history. Functional disorders do not have a physical cause but may result in physical changes. They may be caused by 'faulty usage' or behavioral histories. The features of voice are identified as pitch, quality, loudness, nasal resonance and oral resonance.

Classifying the voice disorders by vocal behaviors or symptoms provides the SLP with useful information. Some examples of functional and organic disorders are:

### FUNCTIONAL DISORDERS

- Contact Ulcers
- Phonation Breaks
- Pitch Breaks
- Traumatic laryngitis
- Vocal Nodules
- Vocal polyps

### ORGANIC DISORDERS

- Cancer
- Laryngectomy
- Pubertal changes
- Vocal fold paralysis

## **VOICE ELIGIBILITY/ENTRY CRITERIA**

A student may be eligible for services as a student who is speech/language impaired in the area of voice when any of the following adversely effect educational performance:

- The formal evaluation reveals voice deviations in pitch, resonance, nasality, intensity, range or rate.
- Formal/informal assessment results reveal voice that is not adequate for success in the regular education curriculum as verified by members of the educational team.

### **Additional Considerations:**

Boone, McFarlane, and Von Berg (2005) suggest that individuals with voice problems should undergo a medical evaluation of the ears, nose, and throat as a component of the complete voice evaluation. If there are problems with vocal quality and/or resonance, a laryngeal evaluation involving laryngoscopy should be completed. Voice therapy should be deferred until a medical examination is completed. It should be noted, the presence of a medical condition (e.g., vocal nodules) does not necessitate the provision of voice therapy as a disability requiring special education, nor does a prescription for voice therapy from a physician.

### **A student is not eligible for services when vocal characteristics:**

- Are the result of temporary physical factors such as allergies, colds, abnormal tonsils or adenoids, short-term vocal abuse or misuse.
- Are the result of regional, dialectic or cultural differences.
- Do not interfere with educational performance.

## VOICE ASSESSMENT

To complete a thorough assessment of voice, it is important to collect a representative sample of the student's speech in a variety of settings. This can be done informally or by using a formal assessment procedure. Regardless of the assessment procedure used it is important to assess the following areas:

- Pitch
- Intensity
- Quality
- Resonance
- Effect on Communication
- Effect on Educational Performance

## VOICE ASSESSMENT PROCEDURES

- Collect data obtained during the pre-referral process
- Obtain classroom teacher input
- Obtain parent input
- Conduct a classroom observation (observe student in structured and unstructured situations in the school environment)
- Review student's school records and/or reports from other agencies
- Interview student to determine self-perception of communication abilities
- Complete an oral-peripheral examination
- Obtain medical report from an Otolaryngologist
- Collect a representative sample of the student's speech
- Analyze voice, pitch, intensity and quality
- Document how the student's voice impairment adversely affects the student's educational performance in the general education classroom or the learning environment.
- Complete the *Voice Severity Rating Scale*

## VOICE DISMISSAL/EXIT CRITERIA

The criteria for exit from services for speech & language impairments should be discussed with IEP team members at the beginning of intervention.

A STUDENT WILL BE RECOMMENDED FOR DISMISSAL WHEN ANY OF THE FOLLOWING OCCUR:

1. Voice goals on the IEP have been accomplished and specially designed instruction is no longer warranted.
2. Voice deficits no longer interfere with the student's ability to perform in the educational setting.
3. Voice deficits no longer interfere with the student's ability to establish and maintain appropriate social/emotional development.
4. The student has other associated and/or handicapping conditions that prevent continued improvement.
5. There is a lack of progress documented over time by charting, therapy data, and/or teacher/parent input or consultation.
6. The student demonstrates a lack of motivation, consistent incompleteness of assignments or inappropriate behaviors that are not conducive to therapy, such as:
  - a. Not being cooperative
  - b. Chronic absenteeism
  - c. Verbally or physically disruptive in therapy
7. Withdrawal is requested by the parent/guardian. This must be obtained in writing and agreed to by the educational team.

### **Additional Considerations:**

When attempting trial therapy for vocal abuse and no improvement is seen within three to six months, the immediate supervisor should be contacted. At that time, a referral for a laryngeal examination should be **discussed**. Continuation of therapy would be contingent upon the results of the examination.

## FORMS/INSTRUCTIONS

Following are rating scales and input forms that will assist the SLP with voice disorders:

- Voice Severity Rating Scale instructions
- Voice Severity Rating Scale
- Classroom Observation Form
- Teacher Input – Voice
- Parent Input – Voice
- Oral Facial Examination
- Vocal Self-Perception: Attitudinal Questionnaire
- Voice Conservation Index for Children
- Vocally Abusive Behaviors Checklist
- Vocal Characteristics Checklist
- Parent Release of Information
- Voice Evaluation Worksheet

## **Voice Severity Rating Scale Instructions**

1. Circle the score for the most appropriate description for each category of the rating scale. Do not include regional or dialectal differences when scoring.
2. Information obtained from a commercial assessment instrument and/or spontaneous communication sample, classroom observation, teacher/parent input or checklists can be utilized to circle appropriate description.
3. To determine the effect of the voice disorder on the student's educational performance, utilize information obtained during classroom observations, teacher/parent input.
4. Add the scores on the **rating scale** & circle the total.
5. Answer yes/no to the final statements at the bottom of the form.

**Criteria: The total score must fall at least within the mild range and the score for "effect on educational performance" must be at least "4" to support a recommendation of eligibility.**

Student: \_\_\_\_\_  
 School: \_\_\_\_\_

Date: \_\_\_\_\_  
 SLP: \_\_\_\_\_

**VOICE SEVERITY RATING SCALE / Formal/Informal Assessment**

	<b>0</b>	<b>1</b>	<b>3</b>
Pitch	Pitch is within normal limits	There is a noticeable difference in pitch which may be intermittent	There is a persistent, noticeable, inappropriate raising or lowering of pitch for age and sex
Intensity	Intensity is within normal limits	There is a noticeable difference in intensity which may be intermittent	There is a persistent, noticeable, inappropriate increase or decrease in the intensity of speech or the presence of aphonia
Quality	Quality is within normal limits	There is a noticeable difference in quality which may be intermittent	There is persistent, noticeable breathiness, glottal fry, harshness, hoarseness, tenseness stridency or other abnormal quality
Resonance	Resonance is within normal limits	There is a noticeable difference in resonance which may be intermittent	There is persistent, noticeable cul de sac, hyper- or hypo-nasality or mixed nasality
	<b>0</b>	<b>2</b>	<b>4</b>
Effect on communication	The voice variation does not affect communication		
Effect on Educational Performance. Social Emotional Academic Vocational	No interference with child's participation in educational setting. Acquisition of basic cognitive and/or affective performance skills is not affected.	Minimal impact on the child's participation in educational setting. Acquisition of basic cognitive and/or affective performance skills may be affected.	Does interfere with child's participation in educational setting. Acquisition of basic cognitive and/or affective performance skills is usually affected.
<b>Total Score</b>	<b>0 2 3 4 5</b>	<b>6 7 8 9 10 11 12 13</b>	<b>14 15 16 17 18 19 20</b>
<b>Rating Scales</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
<input type="checkbox"/> YES <input type="checkbox"/> NO  <input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Based on compilation of the assessment data, this student tcores in the Mild, Moderate or Severe range for a Voice Disorder</p> <p>There is documentation/ supporting evidence of adverse effects of the Voice Disorder on educational performance.</p>		

## Classroom Observation Form

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Class: \_\_\_\_\_

Observer: \_\_\_\_\_

### PRIOR TO OBSERVATION

#### Review Records:

##### Teacher Concerns

#### Student Preparation for/Attention to Instruction:

Yes No Sometimes N/A

- Is prepared for class
- Materials/desk appear organized
- Homework is completed
- Body language indicates positive attitude
- Appears to pay attention
  - In large group
  - In small group
  - In one-on-one
- Stays in seat or work area
- Takes notes
- Follows along in text
- Participates in discussions
- Attends to auditory/visual/multimodality instruction
- Follows two or more speakers
- Remain on-task during observational period

#### Student Response to Instructional Style:

- Asks questions for clarification
- Requests assistance from teacher/peers
- Asks for repetition of instructions
- Answers oral questions with appropriate/related response
- Responds to written instruction
- Looks to others for clues
- Requires additional response time
- Works without reinforcement
- Responds to concrete/verbal reinforcement

#### Student Behavior:

- Follows classroom rules & routine
- Works independently
- Accepts errors/constructive criticism
- Appears accepted by peers
- Seems to like other students

**Student Behavior: (Continued)**

**Yes No Sometimes N/A**

Seems aware of speech/language difficulties  
Uses free time constructively

**Student's Communicative Proficiency:**

**Articulation/Phonology**

Makes sound errors (list sound errors/phonological processes  
you observe child using: \_\_\_\_\_)  
Uses dialectal pattern other than Standard English  
Has difficulty sequencing sounds in multisyllabic words  
Intelligibly interferes with communication

**Voice**

Rate is too fast or too slow  
Voice quality is harsh, breathy, nasal, hoarse  
Voice is intermittently or completely lost  
Pitch is too high or too low  
Volume is too loud or too soft

**Fluency**

Fluency is interrupted by repetitions  
Fluency is interrupted by prolongations or injections  
Fluency is interrupted by secondary characteristics  
Speech causes student frustration  
Speech pattern seems to interfere with communication  
Student hesitates to speak in class  
Others comment on student's speech

**Language**

Maintains eye contact when speaking  
Speaks in complete sentences  
Uses correct question form  
Uses subject-verb agreement  
Uses pronouns correctly  
Uses negation  
Uses plural forms correctly  
Uses appropriate verb tense  
Uses complex sentences  
Uses precise vocabulary  
Appears to have adequate vocabulary  
No apparent word retrieval difficulties  
Relates stories in correct sequence  
Responds correctly to general comprehension questions  
Responds correctly to comprehension questions about specific oral instruction  
Responds correctly to comprehension questions about written passage  
Comprehends concepts of time, space, quantity, quality and directionality



## Teacher Input – Voice

Student \_\_\_\_\_ School \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

*Your observation of the above student's voice will help determine if a voice problem exists which adversely affects educational performance. (Note: Educational performance refers to the student's ability to participate in the educational process and must include consideration of the student's social, emotional, academic and vocational performance.)*

Please return the completed form to the speech/language therapist by \_\_\_\_\_ (date)

Compared to the other children in the classroom.....	Yes	Sometimes	No	N/A
1. Is this student able to project loudly enough to be adequately heard in your classroom during recitations?				
2. Does this student avoid reading out loud in class?				
3. Does this student appear generally to avoid talking in your classroom?				
4. Does this student ever lose his/her voice by the end of the day? If so, when? _____				
5. Does this student use an unusually loud voice or shout a great deal in your classroom?				
6. Does this student engage in an excessive amount of throat clearing or coughing? If so when? _____ If so, does it appear to disturb the other student? (ex., their concentration, listening)				
7. Is this student's voice quality worse during any particular time of the day? If so, when? _____				
8. Does this student's voice quality make it difficult to understand the content of his/her speech?				
9. Does this student's voice quality in itself distract you from what he/she is saying?				
10. Has this student ever mentioned to you that he/she thinks he/she has a voice problem?				
11. Have this student's parents ever talked to you about this student's voice?				
12. Have you ever heard any of his/her peers mention that his/her voice sounds funny or actually make fun of this student because of his/her voice problem?				
13. If this student has a pitch too low or too high, does his/her pitch make it difficult to identify him/her as male/female just by listening?				
14. During speaking, does this student's voice break up or down in pitch to the extent that he/she appears to be embarrassed by this?				

Comments/observations relating to this student's voice: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

It is my opinion that these behaviors \_\_\_\_\_ do/\_\_\_\_\_ do not adversely affect the student's educational performance.

## Parent Input – Voice

Student \_\_\_\_\_ School \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

*Please complete all of the following questions relating to your child's speech. Your observations and responses will help determine if there is a significant problem with your child's voice that adversely impacts educational performance. (Note: Educational performance refers to the student's ability to participate in the educational process and must include consideration of the student's social, emotional, academic and vocational performance).*

Please return the completed form to the speech/language therapist by \_\_\_\_\_ (date)

1. Give approximate date when voice issues were first noticed. _____.
2. In what situation was it first noticed? _____ _____ Under what circumstances did it occur? _____
3. Does your child ever lose his/her voice throughout the day? _____ If so, when _____
4. Does your child use an unusually loud voice or shout a great deal? _____
5. Does your child engage in an excessive amount of throat clearing or coughing? _____ If so, which? _____
6. Is your child's voice quality worse during any particular time of day? _____ If so, when? _____
7. Does your child's voice quality make it difficult to understand the content of his/her speech? _____
8. Does your child's voice quality in itself distract you from what he/she is say? _____
9. Has your child ever mentioned to you he/she thinks that he/she has a voice problem? _____
10. If your child has a pitch too low or too high, does his/her pitch make it difficult to identify him/her as male/female just by listening? _____
11. During speaking, does your child's voice break up or down in pitch to the extent that he/she appears to be embarrassed by this? _____
12. Does your child have allergies, sinus infections, or other chronic conditions, which might contribute to abnormal voice quality? _____
13. Has your child been referred for, or received a total voice evaluation? _____ Is so, when? _____ Results of the evaluation: _____ _____

## ORAL FACIAL EXAMINATION

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Examiner: \_\_\_\_\_

Date: \_\_\_\_\_

**INSTRUCTIONS:** *Observe the physical appearance/movement of the oral mechanism. Circle the corresponding descriptions in each category.*

### I. FACE

1. symmetry: normal/droops on right/droops on left
2. abnormal movements: none/grimaces/spasms
3. mouth breathing: yes/no
4. comments: \_\_\_\_\_

### II. LIPS

*Evaluate appearance of student's lips.*

1. shape: normal/abnormal
2. size: normal/abnormal

*Tell student to pucker.*

1. range of motion: normal/reduced
2. symmetry: normal/droops bilaterally/droops right/droops left
3. strength (*press tongue blade against lips*): normal/weak
4. comment: \_\_\_\_\_

*Tell the student to smile.*

1. range of motion: normal/reduced
2. symmetry: normal/droops bilaterally/droops right/droops left
3. comment: \_\_\_\_\_

*Tell student to puff cheek and hold air.*

1. lip strength: normal/reduced
2. nasal emission: absent/present
3. comment: \_\_\_\_\_

### III. JAW AND TEETH

*Tell student to open and close mouth.*

1. range of motion: normal/reduced
2. symmetry: normal/deviates to right/deviates to left
3. movement: normal/jerky/groping/slow/asymmetrical
4. TMJ noises: absent/grinding/popping

*Observe dentition of student.*

1. occlusion (molar relationship):  
normal  
neuroclulsion (upper and lower arches are correct relationship to each other and to rest of skull – Class I)  
distoclusion (the lower jaw is too far back in relation to the upper arch rest of skull – Class II)  
mesioclulsion (the lower jaw is too far forward in relationship to the upper dental arch and rest of skull – Class III)
2. teeth: all present/dentures/teeth missing (specify)\_\_\_\_\_
3. arrangement of teeth: normal/jumbled/spaces/misaligned
4. occlusion (incisor relationship):  
normal/openbite/overbite/underbite/crossbite/wears orthodontics
5. hygiene:\_\_\_\_\_

#### IV. TONGUE

1. surface color: normal/abnormal
2. abnormal movements: absent/jerky/spasms/writhing
3. size: normal/small/large
4. frenum: normal/short

#### V. LIPS-JAW-TONGUE DIFFERENTIATION:

1. ability to protrude: easy/difficult/not at all
2. ability to retract: easy/difficult/not at all
3. range of motion-left/right: normal/reduced
4. range of motion-up/down: normal/reduced
5. ability to produce tongue pop – normal/reduced

#### VI. TONSILS/ADENOIDS:

1. removed: yes/no
2. size: normal/enlarged/inflamed

#### VII. HARD AND SOFT PALATES:

1. color: normal/abnormal
2. alveolar ridge: normal/very prominent
3. arch height: normal/high/low
4. arch width: normal/narrow/wide
5. fistula (minute opening): absent/present
6. clefting: absent/present

VIII. BREATHING MECHANISM:

1. mouth breather: yes/no
2. adequate for speech purposes: yes/no
3. irregular pattern: shallow/jerky

IX. NASAL CAVITY/RESONANCE:

1. appearance: normal/blockage
2. hyponasal: appropriate/mild/moderate/severe
3. hypernasal: appropriate/mild/moderate/severe
4. audible nasal emission: intermittent/continuous

X. ORAL HABITS:

1. thumb sucking: yes/no
2. tongue sucking: yes/no

XI. DIADOCHOKINESES:

**Instructions:** Time the number of seconds it takes your student to complete each task the prescribed number of times. The average number of seconds for children from 6 to 13 years of age is reported in the right-hand side of the table.

The standard deviation (SD) from the norm (mean or average) is also found in the table. Subtract the SD from the norm to determine each SD interval. For example, using the /pʌ/ norm with a 6-year-old, 3.8 (4.8-1.0) is one SD, 2.8 (4.8-2.0) is two SDs, 2.3 (4.8-2.5) is two-and-a-half SDs, etc. Therefore, a 6 year-old child who needed 2.6 seconds to complete the /pʌ/ sequence would be two SDs below the mean.

			<i>Norms in seconds for diadochokinetic syllable rates</i>								
			Age:								
Task	Repetitions	Seconds	6	7	8	9	10	11	12	13	
pʌ	20	_____	14.8	14.8	4.2	4.0	3.7	3.6	3.4	3.3	
tʌ	20	_____	14.9	14.9	4.4	4.1	3.8	3.6	3.5	3.3	
kʌ	20	_____	15.5	15.3	4.8	4.6	4.3	4.0	3.9	3.7	
	Standard Deviation:		11.0	11.0	0.7	0.7	0.6	0.6	0.6	0.6	
pʌtʌkʌ	10	_____	10.3	10.0	8.3	7.7	7.1	6.5	6.4	5.7	
	Standard Deviation:		12.8	12.8	2.0	2.0	1.5	1.5	1.5	1.5	

### VOCAL SELF-PERCEPTION: ATTITUDINAL QUESTIONNAIRE

1. Do you ever think about your voice?	Yes	No	No Opinion
2. Have you ever heard your voice on tape playback (e.g., on cassette recorder, answering machine)?	Yes	No	No Opinion
3. Did you like your voice on tape playback?	Yes	No	No Opinion
4. Has anyone ever commented on your voice? <i>If Yes, what was said?</i> _____ _____	Yes	No	No Opinion
5. Do you think your voice represents your image of yourself (masculine, feminine, intelligent, educated, friendly, etc.)? <i>If Yes or No, in what way?</i> _____ _____	Yes	No	No Opinion
6. Do any of your friends, male or female, have voices that you especially like? <i>If Yes, explain.</i> _____ _____	Yes	No	No Opinion
7. Do any of your friends, male or female, have voices that you especially dislike? <i>If Yes, explain.</i> _____ _____	Yes	No	No Opinion
8. Does your voice sound like that of any other member of your family? <i>If Yes, explain.</i> _____ _____	Yes	No	No Opinion
9. Circle any words below that describe your voice and the way you speak in general (either on tape replay or while actually talking).			
pleasant sexy raspy hoarse harsh shrill squeaky monotonous nasal mumble husky	too soft high-pitched low-pitched grow too fast too slow weak breathy weak clear	too loud strong thin whiney interesting resonant masculine feminine resonant expressive average	Add any other terms that may describe your voice. _____ _____ _____ _____ _____ _____

## VOICE CONSERVATION INDEX FOR CHILDREN<sup>1</sup>

Child's Initials \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date \_\_\_\_\_

Please circle the answer that is best.

1. When I get a cold, my voice gets hoarse.  
*All the time    Most of the time    Half the time    Once in a while    Never*
2. After cheering at a ballgame, I get hoarse.  
*All the time    Most of the time    Half the time    Once in a while    Never*
3. When I'm in a noisy situation, I stop talking because I think I won't be heard.  
*All the time    Most of the time    Half the time    Once in a while    Never*
4. When I'm in a noisy situation, I speak very loudly.  
*All the time    Most of the time    Half the time    Once in a while    Never*
5. When I'm at home or at school, I spend a lot of time talking every day.  
*All the time    Most of the time    Half the time    Once in a while    Never*
6. I like to talk to people who are far away from me.  
*All the time    Most of the time    Half the time    Once in a while    Never*
7. When I play outside with my friends, I yell a lot.  
*All the time    Most of the time    Half the time    Once in a while    Never*
8. I lose my voice when I don't have a cold.  
*All the time    Most of the time    Half the time    Once in a while    Never*
9. People tell me I talk too loudly.  
*All the time    Most of the time    Half the time    Once in a while    Never*
10. People tell me I never stop talking.  
*All the time    Most of the time    Half the time    Once in a while    Never*
11. I like to talk.  
*All the time    Most of the time    Half the time    Once in a while    Never*
12. I talk on the phone.  
*All the time    Most of the time    Half the time    Once in a while    Never*
13. At home, I talk to people who are in another room.  
*All the time    Most of the time    Half the time    Once in a while    Never*
14. I like to make car or other noises when I play.  
*All the time    Most of the time    Half the time    Once in a while    Never*
15. I like to sing.  
*All the time    Most of the time    Half the time    Once in a while    Never*
16. People don't listen to me unless I talk loudly.  
*All the time    Most of the time    Half the time    Once in a while    Never*

Source: Saniga, R.D. and Carlin, M.F. "Vocal Abuse Behaviors in Young Children". Language, Speech, and Hearing Services in Schools. 1993: 24 (2), p. 83. Reprinted by ASHA with permission of authors.

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<sup>1</sup> Saniga and Carlin (1991)

## VOCALLY ABUSIVE BEHAVIORS CHECKLIST<sup>1</sup>

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Examiner: \_\_\_\_\_

**Instructions:** Have the student evaluate each behavior according to the rating scale. Use the comments column on the right-hand side to add any additional, relevant information.

1 = never                      3 = occasionally                      5 = always  
2 = infrequently              4 = frequently

### Comments

- \_\_\_\_\_ Alcohol consumption \_\_\_\_\_
- \_\_\_\_\_ Arcade talking \_\_\_\_\_
- \_\_\_\_\_ Arguing with peers, siblings, others \_\_\_\_\_
- \_\_\_\_\_ Athletic activity involving yelling \_\_\_\_\_
- \_\_\_\_\_ Breathing through the mouth \_\_\_\_\_
- \_\_\_\_\_ Caffeine products used (coffee, chocolate, etc.) \_\_\_\_\_
- \_\_\_\_\_ Calling others from a distance \_\_\_\_\_
- \_\_\_\_\_ Cheerleading or pep squad participation \_\_\_\_\_
- \_\_\_\_\_ Coughing or sneezing loudly \_\_\_\_\_
- \_\_\_\_\_ Crying \_\_\_\_\_
- \_\_\_\_\_ Dairy products used \_\_\_\_\_
- \_\_\_\_\_ Debate team participation \_\_\_\_\_
- \_\_\_\_\_ Environmental irritants exposure \_\_\_\_\_
- \_\_\_\_\_ Grunting during exercise or lifting \_\_\_\_\_
- \_\_\_\_\_ Inhalants used frequently \_\_\_\_\_
- \_\_\_\_\_ Laughing hard and abusively \_\_\_\_\_
- \_\_\_\_\_ Nightclub social talking \_\_\_\_\_
- \_\_\_\_\_ Participation in plays \_\_\_\_\_
- \_\_\_\_\_ Singing in an abusive manner \_\_\_\_\_
- \_\_\_\_\_ Smoking \_\_\_\_\_
- \_\_\_\_\_ Speeches presented \_\_\_\_\_

<sup>1</sup> Assessment in Speech-Language Pathology 1998 by Singular Publishing Group

**Comments**

- \_\_\_\_\_ Talking loudly during menstrual periods \_\_\_\_\_
- \_\_\_\_\_ Talking loudly during respiratory infections \_\_\_\_\_
- \_\_\_\_\_ Talking for extended periods of time \_\_\_\_\_
- \_\_\_\_\_ Talking in noisy environments \_\_\_\_\_
- \_\_\_\_\_ Talking in smoky environments \_\_\_\_\_
- \_\_\_\_\_ Talking while in car \_\_\_\_\_
- \_\_\_\_\_ Teaching or instructing \_\_\_\_\_
- \_\_\_\_\_ Telephone used frequently \_\_\_\_\_
- \_\_\_\_\_ Vocalizing toy or animal noises \_\_\_\_\_
- \_\_\_\_\_ Vocalizing under muscular tension \_\_\_\_\_
- \_\_\_\_\_ Yelling or screaming \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

## VOCAL CHARACTERISTICS CHECKLIST<sup>1</sup>

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Examiner: \_\_\_\_\_

**Instructions:** Check each characteristic your student exhibits and indicate severity.  
Make additional comments on the right-hand side of the page.

1 = mild

2 = moderate

3 = severe

**Comments**

### Pitch

\_\_\_\_\_ Too high \_\_\_\_\_

\_\_\_\_\_ Too low \_\_\_\_\_

\_\_\_\_\_ Monotone \_\_\_\_\_

\_\_\_\_\_ Limited variation \_\_\_\_\_

\_\_\_\_\_ Excessive variation \_\_\_\_\_

\_\_\_\_\_ Pitch breaks \_\_\_\_\_

\_\_\_\_\_ Diplophonia \_\_\_\_\_

### Loudness

\_\_\_\_\_ Too loud \_\_\_\_\_

\_\_\_\_\_ Too soft or quiet \_\_\_\_\_

\_\_\_\_\_ Monoloudness \_\_\_\_\_

\_\_\_\_\_ Limited variation \_\_\_\_\_

\_\_\_\_\_ Excessive variation \_\_\_\_\_

### Phonatory-Based Quality

\_\_\_\_\_ Breathy voice \_\_\_\_\_

\_\_\_\_\_ Shrill voice \_\_\_\_\_

\_\_\_\_\_ Strident voice \_\_\_\_\_

\_\_\_\_\_ Harsh voice \_\_\_\_\_

\_\_\_\_\_ Hoarse voice \_\_\_\_\_

<sup>1</sup> Assessment in Speech-Language Pathology 1998 by Singular Publishing Group

**Comments**

- \_\_\_\_\_ Quivering voice \_\_\_\_\_
- \_\_\_\_\_ Tremor in the voice \_\_\_\_\_
- \_\_\_\_\_ Weak voice \_\_\_\_\_
- \_\_\_\_\_ Loss of voice \_\_\_\_\_
- \_\_\_\_\_ Glottal fry \_\_\_\_\_

**Nasal Resonance**

- \_\_\_\_\_ Hypernasal \_\_\_\_\_
- \_\_\_\_\_ Nasal emission \_\_\_\_\_
- \_\_\_\_\_ Assimilation nasality \_\_\_\_\_
- \_\_\_\_\_ Hypernasal (denasal) \_\_\_\_\_

**Oral Resonance**

- \_\_\_\_\_ Cul-de-sac \_\_\_\_\_
- \_\_\_\_\_ Chesty \_\_\_\_\_
- \_\_\_\_\_ Thin, babyish voice \_\_\_\_\_

**Other**

- \_\_\_\_\_ Reverse phonation \_\_\_\_\_
- \_\_\_\_\_ Progressively weakening voice \_\_\_\_\_
- \_\_\_\_\_ Aggressive personality factors \_\_\_\_\_
- \_\_\_\_\_ Breathing through the mouth \_\_\_\_\_
- \_\_\_\_\_ Hard glottal attacks \_\_\_\_\_
- \_\_\_\_\_ Inadequate breath support \_\_\_\_\_
- \_\_\_\_\_ Throat clearing \_\_\_\_\_
- \_\_\_\_\_ Disordered intonational patterns \_\_\_\_\_
- \_\_\_\_\_ Disordered stress patterns \_\_\_\_\_



## VOICE EVALUATION WORKSHEETS

Child \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_ SLT \_\_\_\_\_  
 School \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

*Record areas assessed. The assessment should reflect areas of concern described in the referral and those that arise during the evaluation. Areas not assessed should be marked N/A.*

Voice Area	Impairment	Evidence	Adverse Effects on Educational Performance
<b>PHONATION</b>			
<b>Isolation</b>			
Total Pitch Range			
Optimum Pitch			
Pitch Appropriateness for Age			
Pitch Appropriateness for Sex			
Loudness Range			
Aphonia			
Breathiness			
Diplophonia			
Glottal Fry			
Hoarseness			
Harshness			
Tremor			

Child \_\_\_\_\_ Date \_\_\_\_\_

Voice Area	Impairment	Evidence	Adverse Effects on Educational Performance
<b>PHONATION</b> (cont'd)			
<b>Connected Speech</b>			
Voice Onset			
Voiceless to Voiced			
Appropriateness of Loudness			
Pitch Breaks			
Pitch Range			
Habitual Pitch			
Aphonia			
Breathiness			
Diplophonia			
Glottal Fry			
Hoarseness			
Harshness			
Tremor			
<b>RESONANCE IN CONNECTED SPEECH</b>			
Hypernasality			
Hyponasality			
Throatiness/Cul Di Sac			
Nasal Emission			
Assimilation Nasality			

Child \_\_\_\_\_ Date \_\_\_\_\_

<b>Voice Area</b>	<b>Impairment</b>	<b>Evidence</b>	<b>Adverse Effects on Educational Performance</b>
<b>PROSODY IN CONNECTED SPEECH</b>			
Stress			
Intonation			
<b>RESPIRATION</b>			
<b>Type of Breathing Pattern</b>			
At rest			
In Connected Speech			
<b>Breath Support for Speech</b>			
Posture			
Tension			
<b>ASSOCIATED FACTORS</b>			
Vocal Abuse Behaviors			
Personality Factors			
<b>ORAL MECHANISM</b>			
Structure			
Function/Tension			
<b>OTL EXAMINATION RESULTS</b>			

## VII. (CENTRAL) AUDITORY PROCESSING

### DEFINITION/(CENTRAL) AUDITORY PROCESSING

*Auditory Processing is the ability to detect, perceive, comprehend and retain information through the auditory channel.*

**Central Auditory Processes** are the auditory system mechanisms and processes responsible for the following behavior phenomena:

- Sound localization and lateralization
- Auditory discrimination
- Auditory pattern recognition
- Temporal aspects of audition, including -
  - Temporal resolution
  - Temporal masking
  - Temporal integration
  - Temporal ordering
- Auditory performance decrements with competing acoustic signals
- Auditory performance decrements with degraded acoustic signals (ASHA, 2005a)

**A (Central) Auditory Processing Disorder [(C)APD]** is an observed deficiency in one or more of the above-listed behaviors. (C)APD is a deficit in neural processing of auditory stimuli that is not due to higher order language, cognitive, or related factors. However, (C)APD may lead to or be associated with difficulties in higher order language, learning, and communication functions. (C)APD can negatively affect a student's speech, language, reading, writing, social and other related skills (ASHA, 2005a).

### (CENTRAL) AUDITORY PROCESSING ASSESSMENT

#### ASSESSMENT CONSIDERATIONS

The purpose of central auditory processing assessment is to determine if a (C)APD is present and, if so, to describe its parameters. Clinicians need to describe functional auditory performance deficits. A team approach to assessment is the best practice. With children, the neuromaturation status of the auditory nervous system should be considered. Most of the (C)APD diagnostic tests "require that a child be at least 7 or 8 years of age because the variability in brain function is so marked in younger children that test interpretation may not be possible" (Bellis, n. d., ¶7). Further, a central auditory assessment should provide information about both developmental and acquired disorders of the central auditory system.

A comprehensive assessment requires a multidisciplinary approach in order to fully understand of the implications of (C)APD for the individual. The team of professionals determine the functional impact of the diagnosis and guide treatment and management of the disorder and associated deficits; however, speech-language, psychological, and related measures cannot be used to diagnose (C)APD (ASHA, 2005a).

**(C)APD is an auditory deficit; therefore a certified audiologist is the professional who diagnoses (C)APD.**

According to the ASHA *(Central) Auditory Processing Disorders: Technical Report* (2005a),

Factors such as chronological and developmental age; language age and experience; cognitive abilities, including attention and memory; education; linguistic, cultural, and social background; medications; motivation; decision processes; visual acuity; motor skills; and other variables can influence how a given person performs on behavioral tests. Many of these variables also may influence outcomes of some electrophysiologic procedures as well. Audiologists should consider the language, cognitive, and other nonauditory demands of the auditory tasks in selecting a central auditory diagnostic test battery (§19).

(C)APD has been reported in persons manifesting a large and diverse set of clinical problems. (C)APD may have a role in both language learning and language use difficulties of students with and without clear evidence of neuropathology. However, the existence of (C)APD should not be inferred solely from evidence of learning disability or language impairment.

The impact of (C)APD on language use is particularly evident in spoken language comprehension. Because spoken language comprehension is determined by a number of different factors, SLPs should be cautious in attributing spoken language comprehension difficulties to (C)APD in any simple fashion. Thus, a diagnosis of (C)APD requires a comprehensive audiologic assessment. The diagnosis of (C)APD cannot be made solely on the basis of poor comprehension of spoken language.

## **ROLE OF THE SLP**

The SLP's role in (C)APD involves collaborating with the multidisciplinary team during the assessment process, as well as providing intervention, if there is indication of a speech, language, or cognitive-communication disorders. SLPs have the unique role in identifying cognitive-communication and language-related factors that may be associated with (C)APD. Furthermore, SLPs assist in differentiating language processing disorders from (C)APD (ASHA, 2005a)

# AUDITORY PROCESSING ELIGIBILITY/ENTRY CRITERIA

Multiple criteria are necessary to support the recommendation for eligibility as a child with an auditory processing impairment in need of special education services.

The children selected for intervention should meet the following criteria:

- **Intelligence Measurement**  
A performance score of between 85-110 and a verbal score of at least 75 as measured on the WISC or - A classification of average ability as measured by another assessment
- **Hearing Acuity**  
Corrected hearing acuity level of within 25dB through the speech frequencies
- **Receptive Language**  
A language age of not less than one year below chronological age
- **Auditory Processing Measurements**  
At least two years below the child's chronological age in any three of the following six areas:
  - Auditory Discrimination
  - Auditory Memory
  - Auditory Sequencing
  - Auditory Analysis
  - Auditory Synthesis
  - Auditory Figure Ground
- **Effect on Educational Performance**  
Must be at least within the mild range

## EXCLUSIONS

AN AUDITORY PROCESSING IMPAIRMENT DOES NOT EXIST EXCLUSIVELY ON THE BASIS OF:

- Poor comprehension of the spoken word
- A hearing acuity problem
- Evidence of a learning disability or language impairment
- Difficulty in educational performance

# **(CENTRAL) AUDITORY PROCESSING DISORDER ASSESSMENT**

## **ASSESSMENT PROCEDURES**

The diagnosis of a central auditory processing disorder is accomplished using a variety of indices.

- Obtain classroom teacher input
- Obtain parent input
- Conduct a classroom observation
- Non-standardized but systematic observation of auditory behavior
- Audiological test procedures (required to provide specific (C)APD diagnosis)
- Temporal processes
- Ordering
- Discrimination
- Resolution (e.g., gap detection)
- Integration
- Localization and lateralization
- Low-redundancy monaural speech
- Time compressed
- Filtered
- Interrupted
- Competing
- Dichotic stimuli, including competing nonsense syllables, digits, words and sentences
- Binaural interaction procedures (e.g., masking level difference)
- Electrophysiological information

# VIII. TRAUMATIC BRAIN INJURY/COGNITIVE-COMMUNICATION DISORDERS

## DEFINITION/TRAUMATIC BRAIN INJURY

Traumatic Brain injury (TBI) is defined within the IDEA as an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. The term applies to open and closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem solving; sensory, perceptual and motor abilities; psychosocial behavior; physical functions; information processing and speech. The term does not apply to brain injuries that are congenital or degenerative, or brain injuries induced by birth trauma.

## TYPES OF TBI

**Penetrating Injuries:** A foreign object (e.g., a bullet) enters the brain and causes damage to specific brain parts. This focal, or localized, damage occurs along the route the object has traveled in the brain. Symptoms vary depending on the part of the brain that is damaged.

**Closed Head Injuries:** Closed head injuries result from a blow to the head as occurs, for example, in a car accident when the head strikes the windshield or dashboard. These injuries cause two types of brain damage:

Primary brain damage, which is damage that is complete at the time of impact, may include:

- skull fracture: breaking of the bony skull
- contusions/bruises: often occur right under the location of impact or at points where the force of the blow has driven the brain against the bony ridges inside the skull
- hematomas/blood clots: occur between the skull and the brain or inside the brain itself
- lacerations: tearing of the frontal (front) and temporal (on the side) lobes or blood vessels of the brain (the force of the blow causes the brain to rotate across the hard ridges of the skull, causing the tears)
- nerve damage (diffuse axonal injury): arises from a cutting, or shearing, force from the blow that damages nerve cells in the brain's connecting nerve fibers

Secondary brain damage, which is damage that evolves over time after the trauma, may include:

- brain swelling (edema)
- increased pressure inside of the skull (intracranial pressure)
- epilepsy
- intracranial infection
- fever
- hematoma
- low or high blood pressure
- low sodium
- anemia
- too much or too little carbon dioxide
- abnormal blood coagulation
- cardiac changes
- lung changes
- nutritional changes

## **PHYSICAL PROBLEMS**

Physical problems following TBI may include:

- hearing loss
- tinnitus (ringing or buzzing in the ears)
- headaches
- seizures
- dizziness
- nausea
- vomiting
- blurred vision
- decreased smell or taste
- reduced strength and coordination in the body, arms, and legs

## **COMMUNICATION DEFICITS**

Communication deficits following TBI may include:

- difficulty finding words when speaking and/or writing
- difficulty spelling, writing, and reading
- difficulty speaking clearly (i. e., dysarthria)
- reduced oral motor strength, range of motion, and coordination
- reduced vocal loudness
- social communication
- taking turns in conversation
- maintaining a conversational topic
- using conversational turn-taking
- using an appropriate tone of voice
- understanding figurative language and sarcasm
- understanding and responding to non-verbal aspects of communication (e. g., facial expressions and body language)
- flat emotional affect
- lack of awareness of inappropriate actions/behavior

## **COGNITIVE DEFICITS**

Cognitive deficits following TBI may include:

- difficulty concentrating/attending to tasks
- memory
- reasoning
- problem solving
- executive functioning (e. g., goal setting, planning, initiating, self-awareness, and self-monitoring)
- difficulty processing and learning new information (ASHA, 2013)

## **CONSIDERATIONS FOR TBI**

Each student who has experienced a TBI is unique due to pre-injury cognitive ability, personality, learning style, the extent of damage and the time elapsed since the trauma. TBI generates a broad spectrum of neuropsychological and communicative deficits ranging from mild to profound. Communication is frequently impaired in the areas of attention, memory, orientation, knowledge of general information, abstract reasoning, problem solving, sequencing, organization and pragmatic language skills.

## **TBI ELIGIBILITY/ENTRY CRITERIA**

Eligibility for services should be documented with appropriate formal assessments, informal tests, observations of educational performance and professional judgment. This should be accomplished in conjunction with additional input from members of the Multidisciplinary Team.

As students with TBI are recovering, it is expected that their cognitive abilities will improve. For this reason, it is necessary for frequent reassessment of both cognitive functioning and language abilities to update and revise intervention.

## **ROLE OF THE SLP**

The SLP may assume a major role in developing a program for cognitive retraining, managing memory problems and compensatory strategies in addition to implementing standard language intervention strategies.

## **TBI ASSESSMENT**

- Specific issues which professionals who are assessing students with TBI should consider:
- Medical history
- Educational history
- Sequela of the injury and implications of the deficits on assessment
- Timing of assessment
- Redundancy in assessment across agencies
- Changes in the individual regarding strengths and needs
- Developmental issues
- Effects of medication on performance
- Overall cognitive-communication demands of the assessment
- Parent/teacher input regarding behavior, personality and learning styles

## **ASSESSMENT PROCEDURES**

Students with TBI may display disorders of articulation, language, voice, or fluency. The assessment procedures should be followed for the respective area of suspected impairment as delineated in the previous sections of the criteria manual. Furthermore, the assessment should involve informal and/or formal assessment of the student's attention, memory, orientation, knowledge of general information, abstract reasoning, problem solving, sequencing, organization and pragmatic language skills. The use of the TBI Communication Skills Checklist may prove to be beneficial when assessing students with TBI.

## **DEFINITION/COGNITIVE-COMMUNICATION DISORDERS**

Cognitive communication is “the ability to use language and underlying skills such as attention, memory, self-awareness, organization, and problem-solving skills to communicate effectively” (DePompei, 2010, ¶4). Cognitive-communication disorders “encompass difficulty with any aspect of communication that is affected by disruption of cognition” (ASHA, 2005c, ¶2). There are many cognitive processes that underlie language development. When these cognitive processes are impaired, deficits in language will be the outward manifestation that indicates the underlying problems. These cognitive processes include:

- Impaired attention, perception, and/or memory
- Inflexibility, impulsivity, disorganized thinking
- Difficulty processing complex information
- Problems learning new information
- Inefficient retrieval of stored information
- Inefficient problem solving or judgment
- Inappropriate social behavior (pragmatics)
- Impaired executive functioning

## **COGNITIVE-COMMUNICATION DISORDERS ELIGIBILITY/ENTRY CRITERIA**

It is necessary to document a need for speech/language support services for students who have cognitive-communication disorders. Eligibility for services should be documented with appropriate formal assessments, informal tests, observations of educational performance and professional judgment. This should be accomplished in conjunction with additional input from members of the Multidisciplinary Team.

## ROLE OF THE SLP

“SLPs are knowledgeable about normal and abnormal development, brain-behavior relationships, pathophysiology, and neuropsychological processes as related to the cognitive aspects of communication” (ASHA, 2005c, ¶6). SLPs may assume a variety of roles pertaining to the assessment and treatment of students with cognitive-communication disorders. The role of the SLP includes, but is not limited to the following:

- **Identification:** Identifying individuals at risk for or presenting with cognitive-communication disorders.
- **Assessment:** Selecting and implementing clinically, culturally, and linguistically appropriate approaches to assessment and diagnosis, using both static and dynamic procedures. Identifying contextual factors that contribute to or can be used to ameliorate cognitive-communication disorders.
- **Intervention:** Selecting and implementing clinically, culturally, and linguistically appropriate and evidence-based approaches to intervention (e.g., training discrete cognitive processes, teaching specific functional skills, developing compensatory strategies and support systems, providing caregiver training, and providing counseling and behavioral support services).
- **Counseling:** Providing culturally and linguistically appropriate counseling for individuals and their significant others about cognitive-communication disorders and their impact.
- **Collaboration:** Collaborating with the individual with a cognitive-communication disorder, family members, teachers and other professional colleagues, care providers, and others in developing and implementing assessment and intervention plans.
- **Case Management:** Serving as case manager, service coordinator, or team leader by coordinating, monitoring, and ensuring the appropriate and timely delivery of a comprehensive management plan.
- **Education:** Developing curricula and educating, supervising, and mentoring future speech-language pathologists in assessment and treatment options and other issues related to cognitive-communication disorders. Educating families, caregivers, and other professionals regarding the needs of individuals with cognitive-communication disorders.
- **Prevention:** Educating the public on the prevention of factors contributing to cognitive-communication disorders.
- **Advocacy:** Advocating for services for individuals with cognitive-communication disorders. Serving as an expert witness.
- **Research:** Advancing the knowledge base on cognitive-communication disorders and their treatment through research activities (ASHA, 2005c, ¶7).

## **COGNITIVE-COMMUNICATION DISORDERS ASSESSMENT**

Students with cognitive-communication impairments may display disorders of articulation, language, voice, or fluency. The assessment procedures should be followed for the respective area of suspected impairment as delineated in the previous sections of the criteria manual. Furthermore, the use of curriculum-based assessment and a functional communication assessment may prove to be beneficial when assessing students with cognitive-communication impairments.

## Traumatic Brain Injury SKILLS RATING CHECKLIST

Student Name \_\_\_\_\_ Date \_\_\_\_\_  
 Grade \_\_\_\_\_ Birthday \_\_\_\_\_ Student Number \_\_\_\_\_  
 School \_\_\_\_\_ Person rating student \_\_\_\_\_

### Academic Skills

Check the description that best describes the child

	Not at all	Just a little	Pretty much	Very much
<b>Decreased ability to plan</b>				
1. Does not recognize due dates, or time required to complete class projects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has difficulty getting to class on time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Forgets to bring materials for class.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Forgets to prepare for a field trip.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Decreased ability to store and retrieve information upon demand.</b>				
5. Has little concern for details.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Unable to recall specific details or sequence of a lesson.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Decreased carryover for new learning.</b>				
7. Cannot recall or generalize information presented in class.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Decreased ability to generalize learned information to new or different situations.</b>				
8. Is unable or refuses to take tests where newly learned information must be applied or generated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lack of initiative.</b>				
9. Forgets; does not complete or does not turn in homework.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Decreased ability to stay on task.</b>				
10. Is unable to begin and/or complete timed tests.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Is unable to sit still in class.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Skips around while doing assignments; completes only parts of assignments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Inability to perform well in competitive and stressful situations.</b>				
13. Has low tolerance for timed test situations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Cannot complete work in the allowed time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Argues and fights with peers during activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Low tolerance for frustration.</b>				
16. Has outburst of temper when others would try a different approach or request help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Inconsistent performance.</b>				
17. Does similar work correctly one day; incorrectly the next.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Demonstrates model behavior one day and totally inappropriate behavior the next.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### TBI SKILLS RATING CHECKLIST



Student Name \_\_\_\_\_ Student Number \_\_\_\_\_ Date \_\_\_\_\_

**Not at all    Just a little    Pretty much    Very much**

**Inability to comply with classroom rules and teacher expectations.**

- 19. Is withdrawn and not willing to participate in group activities.
- 20. Refuses to recite in class.

**Rude, silly, immature for age.**

- 21. Makes inappropriate comments to fellow students and teachers.
- 22. Laughs out loud during serious discussions or quiet seatwork

**Verbally aggressive.**

- 23. Interrupts conversations.

**Expressive Language**

**Delayed Responses.**

- 24. Does not answer immediately; appears not to know the answer.
- 25. Uses "this," "that," "those things," "watchamacalits."

**Word Retrieval errors.**

- 26. Difficulty providing answers on tests.
- 27. Has disorganized syntax and difficulty thinking of words.

**Perseveration on words or phrases**

- 28. Starts to respond and gets "stuck" in the middle of a sentence.  
 Repeats words or phrases (i.e., "He went, he went, he went...").

**Inadequate labeling or vocabulary to convey clear message.**

- 29. Mislabels common objects, tools, materials, etc.

**Tangential communication.**

- 30. Rambles. Does not acknowledge listener's interest or attention.

**Communication in informal situations differs from formal.**

- 31. Answers questions at a surface level; unable to provide a detailed explanation.
- 32. Converses well in social situations; conversation in classroom lacks depth.

**Inability to describe events in sequence.**

- 33. Relates details out of order.
- 34. Can't explain directions for playing a game or doing an assignment.

**Difficulty with abstract language; ambiguity, satire, inferences, drawing conclusions.**

- 35. Says things that classmates interpret as satirical, funny or bizarre, although they were not intended to be that way.

**Reduced verbal reasoning ability.**

- 36. Gives a correct answer but unable to list the steps followed to solve a problem.

## TBI SKILLS RATING CHECKLIST



Student Name \_\_\_\_\_ Student Number \_\_\_\_\_ Date \_\_\_\_\_

### Receptive Language

**Not at all    Just a little    Pretty much    Very much**

**Inability to determine salient features of "Wh..." questions, verbal information, or assignments read.**

37. Completes the wrong assignment (e.g., instead of problems 9-12, student does 1-9).                  

**Inability to determine the specific aspects of questions that need to be asked.**

38. Gets details confused when answering questions about details of a lesson.                  

39. Responses may be related to specific questions, but not exact.                  

40. Unable to decipher long story problems.                  

**Failure to organize verbal or written information.**

41. Performs steps out of sequence or fixates on one step.                  

**Inability to analyze or integrate information.**

42. Disorganized or incomplete work.                  

43. Confuses verbal directions; goes to the wrong room.                  

**Easily over-loaded.**

44. Appears to be daydreaming or non-responsive.                  

**Inability to read nonverbal cues.**

45. Unaware that the teacher or other classmates do not want to be bothered while working.                  

46. Interrupts others.                  

**Poor comprehension of lengthy or rapid speech.**

47. Has poor notetaking skills; unable to select salient facts.                  

**Difficulty understanding a sequence of events.**

48. Gets lost in the daily routine (knowing order or location of classes).                  

**Difficulty with attention and comprehension.**

49. Loses place while reading.                  

**Ability to concentrate is decreased.**

50. Unable to relate information recently read.                  

51. Easily distracted during reading assignments.                  

52. Unable to complete silent reading and seatwork assignments at the same rate as classmates.                  

**Reduced ability to understand abstract language.**

53. Misunderstands instructions and comments made.                  

54. Does not understand humor.

**TBI SKILLS RATING CHECKLIST**



**Written Language**

Not at all    Just a little    Pretty much    Very much

**Structure and content of the writing may not be of the same skill level as preinjury.**

55. Has numerous grammatical errors in essays.               

**Sentence structure is simplistic and syntax disorganized.**

56. Uses incorrect and unorganized sentence structure               

57. Writes below age and grade level; themes may be simplistic, short and dry.               

58. Does not use figurative language; writing contains irrelevant or unsubstantial information.               

**Decreased speed and accuracy. Poor handwriting.**

59. Does poorly on timed tests.               

**General Behaviors – Social Skills**

**Decreased judgment.**

60. Is easily persuaded by others.               

61. Is impulsive.               

62. Speaks out of turn in class, gets up and moves or leaves classroom.               

63. Is careless about safety. Does not look before crossing street, poor decisions about playing on the playground or activities in PE class.               

**Inability to plan for the future.**

64. Resents supervision.               

65. Does not recognize physical or cognitive limitations.               

**Lacks self-insight.**

66. Doesn't understand other person's reaction to his behavior.               

67. Responds defensively to comments made or questions asked by teachers or fellow students.               

**Poor problem solving skills.**

68. Solutions to situations are not carefully thought out.               

**Additional concerns, observations or comments:**

.....

# IX. DYSPHAGIA

Feeding and Swallowing Disorders

## DEFINITION/DYSPHAGIA

**Dysphagia** is defined as difficulty in swallowing; may include inflammation, compression, paralysis, weakness, or hypertonicity of the esophagus.

**Swallow** is defined as the following:

1. to pass a substance through the oral cavity and pharynx, past the cricopharyngeal constriction, and into the esophagus; an act usually initiated voluntarily but almost always performed reflexively. It may be divided into four phases: (a) *oral preparatory phase*, when food is manipulated in the mouth and masticated if necessary; (b) *oral or voluntary phases*, when the tongue propels food posteriorly until the swallowing reflex is triggered; (c) *pharyngeal phase*, when the reflexive swallow carries the food through the pharynx; (d) *esophageal phase*, when the food is propelled through the cervical and thoracic esophagus into the stomach. 2. A complex motor sequence involving the coordination of a large number of muscles in the mouth, pharynx, larynx, and the esophagus. Provides the mechanism by which food is transported to the alimentary tract for the survival of the individual.

## Swallowing Disorder

A swallowing disorder occurs when an impairment reduces an individual's ability to get adequate nutrition by mouth, or when it raises the danger of aspiration of foodstuffs or liquid into the lungs rather than the stomach.

**Feeding** is defined as the following:

- Placement, manipulation, and mastication of food in the oral cavity prior to initiation of the swallow.
- The giving or taking of food.
- Administration of nourishment.

# **DYSPHAGIA TEAM MEMBERS**

All members of the dysphagia team have a role to play in ensuring the safety of children at school. According to Arvedson (2000), "Most feeding and swallowing disorders do not occur in isolation, but are part of a broader spectrum of disabilities" (p. 29). Effective evaluation and management may require the expertise of several disciplines. Swallowing and feeding disorders are best addressed using an interdisciplinary team approach. The school-based team consists of core members who are primarily responsible for decisions regarding dysphagia. The primary members of the dysphagia team consist of:

- Speech-Language Pathologist
- Occupational Therapist
- School Nurse
- Social Worker
- Dietician
- School Administrator
- Classroom Teacher
- Paraprofessional
- Physician
- Parent
- Student

## **Occupational therapist**

- addresses fine motor skills related to self-feeding;
- addresses sensory and regulation issues;
- addresses positioning and adaptive equipment for eating.

## **School nurse**

- monitors the health, weight, and overall nutrition status of the student;
- writes the IHP (emergency plan) and trains personnel;
- monitors respiration periodically as needed;
- troubleshoots issues related to tracheostomies, feeding tubes, ventilators, etc.;
- assists in contacting and communicating with physicians;
- consults with parent/guardian and teachers;
- administers or assists with administering tube feeding and/or medications.

## **Classroom teacher**

- implements the swallowing and feeding plan in the classroom;
- monitors changes in student's swallowing and feeding in daily classroom activities;
- coordinates the personnel responsible for feeding students;
- communicates with the parent/guardian;
- implements the IHP/emergency plan as needed;
- oversees mealtime environment to make it safe in the classroom or cafeteria;
- supports communication and social goals during feeding.

## **Physical therapist**

- addresses postural skills and mobility issues;
- addresses positioning and adaptive equipment needs related to positioning for mealtimes.

## **Parent/guardian**

- shares knowledge of student's feeding habits, food preferences, and mealtime environment;
- provides medical and feeding history including food allergies, dietary restrictions, and medications;
- shares beliefs related to foods and eating;
- implements swallowing and feeding goals and strategies in home and community environments.

## **ROLE OF THE SLP IN DYSPHAGIA SERVICES IN THE SCHOOLS**

Speech-language pathologists have a vital role in assessing and treating students with dysphagia in the school setting. The Rehabilitation Act of 1973 (Section 504) and IDEA 2004 require services be provided to students with health-related issues in order for the students to participate fully in their educational program.

The educational relevance of providing dysphagia services in the school setting is as follows:

1. Students must be safe while eating in school. This includes providing appropriate personnel, food, and procedures to reduce risks of choking and aspiration during meals.
2. Students must be adequately nourished and hydrated so they can fully participate in their educational program.
3. Students must be healthy (e.g. free from aspiration pneumonia or other illnesses related to dysphagia) to maximize their attendance at school.
4. Students must develop adequate skills for eating meals and snacks during school hours in order to participate safely with peers.
5. Proper clearances must be in the student's school file for sharing information and referring the student for needed medical follow-up related to dysphagia.

School based SLPs are responsible for referring the students on their caseloads that have signs and symptoms of dysphagia. If the school based SLP has experience in the area of swallowing disorders, then he/she may be assigned the role of Case Manager. The Case Manager is responsible for insuring that the procedure is followed and documented. Once the student has been diagnosed as having a swallowing disorder, the school based SLP will design and implement a feeding/swallowing plan for therapy. If the SLP at the school does not have training/experience in dysphagia, then a Case Manager will be assigned to assist the therapist in working with the student, parents, and teachers.

## **ADDITIONAL CONSIDERTIONS OF THE SLP**

### **ETHICAL ISSUES**

Professional and ethical standards are defined by ASHA's Code of Ethics (ASHA, 2010a) and practice policy documents. State licensing boards may also set standards for professional and ethical practice within the state. Certified SLPs living in states with licensure requirements must adhere to both standards. ASHA's Scope of Practice in Speech-Language Pathology includes assessment and management of swallowing disorders and the use of instrumentation for the diagnosis of swallowing and feeding disorders (ASHA, 2007). ASHA's Code of Ethics mandates that SLPs must be competent in any area of service that they deliver (ASHA, 2010a). Therefore, SLPs who manage swallowing and feeding in the schools are ethically bound to achieve and maintain competence in this area of practice.

### **COMPETENCY ISSUES**

As dysphagia practice continues to evolve, it is incumbent on SLPs to continually update their knowledge of research and practice involving swallowing and feeding for students in the schools. Mechanisms to develop competency in providing swallowing and feeding services in schools may include the following:

- classes or workshops to acquire, maintain, and update knowledge and skills about normal swallowing and feeding development in the pediatric population and assessment and management of swallowing and feeding disorders in students with various etiologies;
- mentored observations of swallowing and feeding assessment and treatment;
- mentored hands-on clinical experiences verification/documentation of competency level in accordance with organizational policy;
- training in policy and procedures in the school's swallowing program (e.g. process, forms, team function, documentation).

## **DYSPHAGIA ELIGIBILITY/ENTRY CRITERIA**

Dysphagia is NOT considered a specific eligibility for special education; however, some students may have other disabilities of which dysphagia is an accompanying disorder.

Swallowing disorder symptoms include but are not limited to:

1. Excessive mouth movement during chewing and swallowing
2. Difficulty starting a swallow
3. Coughing or choking while eating or drinking
4. Coughing or choking after eating or drinking
5. Needing to swallow two or three times
6. Food remaining on tongue after swallowing
7. Pocketing of food on one side of mouth
8. Excessive drooling, especially immediately after eating
9. A large amount of extra secretions
10. Gargley-sounding voice after eating or drinking
11. Increased body temperature of unknown cause
12. Pneumonia
13. Chronic respiratory distress
14. Weight loss when no other reason can be defined
15. Controlling food, liquid, and/or saliva in the mouth

# FEEDING/SWALLOWING SCREENING AND ASSESSMENT

A feeding/swallowing assessment gathers information regarding the oral and pharyngeal phases of swallowing to determine if dysphagia is present to the extent that the health, safety, and well-being of the student is compromised within the school environment. Assessment procedures should include observation of the student during mealtime or within the mealtime environment. Initial contacts with the parent, teacher, and physician should be made regarding feeding/swallowing difficulties.

## ASSESSMENT PROCEDURES:

- IEP team member suspects that student has difficulties with feeding/swallowing and exhibits a need for feeding assessment
- If an initial ER, issue a Permission to Evaluate and indicate “swallowing/feeding assessment” as one of the assessments to be conducted
- If a reevaluation, begin RR process by addressing the first 7 sections and making determination that additional information is necessary
- Issue Permission to Reevaluate – “swallowing/feeding assessment
- Conduct evaluation/reevaluation:
  - Teacher Input
  - Parent Input
  - Oral Facial Examination
  - Swallowing assessment
  - Disseminate assessment findings with recommendations to
  - Team Member completing ER/RR report.
- If student is in need of treatment for swallowing/feeding, IEP team will meet to develop goals/objectives
- NOREP issued ( if district determines it is necessary)
- Implement IEP
- Forward copy of relevant findings/recommendations to child’s physician

## **DYSPHAGIA DISMISSAL/EXIT CRITERIA**

The criteria for exit from services for speech and language impairments should be discussed with IEP team members at the beginning of intervention.

### ***A STUDENT WILL BE RECOMMENDED FOR DISMISSAL WHEN THE FOLLOWING CONDITIONS OCCUR:***

1. The student is able to safely eat a variety of foods and textures appropriate for his/her developmental stage.
2. The student is not tube fed.
3. The student does not need any special, adaptive equipment for feeding.
4. The student is not on a special diet such as puree, mechanical- chopped, etc.
5. The student is not a health risk for failure to thrive due to poor nutrition as a result of the inability to swallow, chew, etc.
6. The health, safety, and well being of the student are no longer compromised within the school environment.

## IX. FORMS/INSTRUCTIONS

The following are input, observation, and assessment forms that will assist the SLP with the diagnosis of dysphagia:

- Authorization to Release Information
- Parent Input-Feeding/Swallowing
- Teacher Input Form-Feeding/Swallowing
- Oral Facial Examination
- Feeding/Swallowing Observation/Evaluation
- Type and Severity of Dysphagia
- Feeding/Swallowing Plan



## PARENT INPUT- Feeding/Swallowing

Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Current Weight and Height: \_\_\_\_\_

Physician: \_\_\_\_\_

Please complete all of the following questions relating to your child's feeding/swallowing. Your observations and responses concerning your child will help determine if a feeding/swallowing disorder compromises the health, safety, and well being of your child within the school environment to such an extent that it adversely effects the educational performance. (Note: Educational performance refers to the student's ability to participate in the educational process and must include consideration of the student's social, emotional, academic, and vocational performance.)

Does your child feed himself/herself?

- YES  NO  
 Yes, with assistance  
 Yes, independently

Does you child enjoy mealtime?

- YES  NO

How do you know when your child is hungry?

---

---

How do you know when your child is full?

---

---

How long does it take your child to complete a meal?

- 10-20 min  20-30 min  30-40 min  >60 min.

Does you child have difficulty with any of the following?

- YES  NO

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Choking during a meal                       | <input type="checkbox"/> Tongue thrust         | <input type="checkbox"/> Very fussy eating behaviors |
| <input type="checkbox"/> Chewing Breathing                           | <input type="checkbox"/> Chronic ear infection | <input type="checkbox"/> Noisy breathing             |
| <input type="checkbox"/> Gurgly or "wet" voice                       | <input type="checkbox"/> Gagging               | <input type="checkbox"/> Vomiting                    |
| <input type="checkbox"/> Biting on utensils                          | <input type="checkbox"/> Drooling              |  |
| <input type="checkbox"/> Coughing with or without spraying of food   |  |  |
| <input type="checkbox"/> Chronic respiratory problems (pneumonia)    |  |  |
| <input type="checkbox"/> Sensitive to being touched around the mouth |  |  |

Drooling:  constant  frequent  occasional

Was or is your child fed through feeding tube?

- YES  NO

If yes, then when?

---

- Why?  Aspiration  Medication  Transition to Oral Feeding  
 Liquids Only  Other

What are your child's food preferences?

Likes

Dislikes

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What kinds of food does your child eat?

- Liquids       Thickened liquids       Pureed       Mashed       Semi-Solids
- Chopped       Bite-sized pieces       Table foods (whatever your family is eating)

Does your child take any nutritional supplements?       YES       NO

If yes, specify \_\_\_\_\_

Do certain foods/liquids appear to be more difficult for your child to eat?       YES       NO

If yes, specify \_\_\_\_\_

How is your child positioned during feeding?

- Sitting in a chair       Sitting in a wheelchair       Sitting
- Held on lap       Reclined       Lying down
- Other \_\_\_\_\_

What utensils are used?

- Bottle       Spoon       Sippy cup       Cup (no lid)

Other adaptive equipment: \_\_\_\_\_

Has your child ever had a swallow study?       YES       NO

If yes, when? \_\_\_\_\_

What were the results? \_\_\_\_\_

Additional Comments or Concerns: \_\_\_\_\_

\_\_\_\_\_

Rate the impact of the student's feeding/swallowing disorder on his/her social, emotional, academic, and/or vocational functioning:

Check One:

- does not interfere       minimal impact       interferes       seriously limits

\_\_\_\_\_  
**PARENT SIGNATURE/DATE**

TEACHER INPUT FORM- Feeding/Swallowing

Student: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Classroom Teacher: \_\_\_\_\_

Please check all that apply:

**OBSERVED BEHAVIORS**

- Requires special diet or diet modification (i.e. baby foods, thickener, soft food only)
- Poor upper body control
- Poor oral motor functioning
- Maintains open mouth posture
- Drooling
- Nasal regurgitation
- Food remains in mouth after meals (pocketing)
- Wet breath sounds and/or gurgly voice quality following meals or drinking
- Coughing/choking during meals
- Swallowing solid food without chewing
- Effortful swallowing
- Eyes watering/tearing during mealtime
- Unusual head/neck posturing during eating
- Hypersensitive gag reflex
- Refusal to eat
- Food and/or drink escaping from the mouth or trach tube
- Spitting up or vomiting associated with eating and drinking
- Slurred speech
- Mealtime takes more than 30 minutes

Additional Information or Comments: \_\_\_\_\_

\_\_\_\_\_

Rate the impact of the student's feeding/swallowing disorder on his/her social, emotional, academic, and/or vocational functioning:

*Check One:*

- does not interfere
- minimal impact
- interferes
- seriously limits

## ORAL FACIAL EXAMINATION

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Examiner: \_\_\_\_\_ Date: \_\_\_\_\_

**INSTRUCTIONS:** *Observe the physical appearance/movement of the oral mechanism. Circle the corresponding descriptions in each category.*

### I. FACE

1. symmetry: normal/droops on right/droops on left
2. abnormal movements: none/grimaces/spasms
3. mouth breathing: yes/no
4. comments: \_\_\_\_\_

### II. LIPS

*Evaluate appearance of student's lips.*

1. shape: normal/abnormal
2. size: normal/abnormal

*Tell student to pucker.*

1. range of motion: normal/reduced
2. symmetry: normal/droops bilaterally/droops right/droops left
3. strength (*press tongue blade against lips*): normal/weak
4. comment: \_\_\_\_\_

*Tell the student to smile.*

1. range of motion: normal/reduced
2. symmetry: normal/droops bilaterally/droops right/droops left
3. comment: \_\_\_\_\_

*Tell student to puff cheek and hold air.*

1. lip strength: normal/reduced
2. nasal emission: absent/present
3. comment: \_\_\_\_\_

### III. JAW AND TEETH

*Tell student to open and close mouth.*

1. range of motion: normal/reduced
2. symmetry: normal/deviates to right/deviates to left
3. movement: normal/jerky/groping/slow/asymmetrical
4. TMJ noises: absent/grinding/popping

*Observe dentition of student.*

1. occlusion (molar relationship):  
normal  
neutroclusion (upper and lower arches are correct relationship to each other and to rest of skull – Class I)  
distocclusion (the lower jaw is too far back in relation to the upper arch rest of skull – Class II)  
mesiocclusion (the lower jaw is too far forward in relationship to the upper dental arch and rest of skull – Class III)
2. teeth: all present/dentures/teeth missing (specify)\_\_\_\_\_
3. arrangement of teeth: normal/jumbled/spaces/misaligned
4. occlusion (incisor relationship):  
normal/openbite/overbite/underbite/crossbite/wears orthodontics
5. hygiene:\_\_\_\_\_

#### IV. TONGUE

1. surface color: normal/abnormal
2. abnormal movements: absent/jerky/spasms/writhing
3. size: normal/small/large
4. frenum: normal/short

#### V. LIPS-JAW-TONGUE DIFFERENTIATION:

1. ability to protrude: easy/difficult/not at all
2. ability to retract: easy/difficult/not at all
3. range of motion-left/right: normal/reduced
4. range of motion-up/down: normal/reduced
5. ability to produce tongue pop – normal/reduced

#### VI. TONSILS/ADENOIDS:

1. removed: yes/no
2. size: normal/enlarged/inflamed

#### VII. HARD AND SOFT PALATES:

1. color: normal/abnormal
2. alveolar ridge: normal/very prominent
3. arch height: normal/high/low
4. arch width: normal/narrow/wide
5. fistula (minute opening): absent/present
6. clefting: absent/present

VIII. BREATHING MECHANISM:

1. mouth breather: yes/no
2. adequate for speech purposes: yes/no
3. irregular pattern: shallow/jerky

IX. NASAL CAVITY/RESONANCE:

1. appearance: normal/blockage
2. hyponasal: appropriate/mild/moderate/severe
3. hypernasal: appropriate/mild/moderate/severe
4. audible nasal emission: intermittent/continuous

X. ORAL HABITS:

1. thumb sucking: yes/no
2. tongue sucking: yes/no

XI. DIADOCHOKINESES:

**Instructions:** Time the number of seconds it takes your student to complete each task the prescribed number of times. The average number of seconds for children from 6 to 13 years of age is reported in the right-hand side of the table.

The standard deviation (SD) from the norm (mean or average) is also found in the table. Subtract the SD from the norm to determine each SD interval. For example, using the /pʌ/ norm with a 6-year-old, 3.8 (4.8-1.0) is one SD, 2.8 (4.8-2.0) is two SDs, 2.3 (4.8-2.5) is two-and-a-half SDs, etc. Therefore, a 6 year-old child who needed 2.6 seconds to complete the /pʌ/ sequence would be two SDs below the mean.

			<i>Norms in seconds for diadochokinetic syllable rates</i>							
			Age:							
Task	Repetitions	Seconds	6	7	8	9	10	11	12	13
pʌ	20	_____	14.8	14.8	4.2	4.0	3.7	3.6	3.4	3.3
tʌ	20	_____	14.9	14.9	4.4	4.1	3.8	3.6	3.5	3.3
kʌ	20	_____	15.5	15.3	4.8	4.6	4.3	4.0	3.9	3.7
	Standard Deviation:		11.0	11.0	0.7	0.7	0.6	0.6	0.6	0.6
pʌtʌkʌ	10	_____	10.3	10.0	8.3	7.7	7.1	6.5	6.4	5.7
	Standard Deviation:		12.8	12.8	2.0	2.0	1.5	1.5	1.5	1.5

# FEEDING/SWALLOWING OBSERVATION/EVALUATION

Date of Consultation: \_\_\_\_\_

Student: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Exceptionality: \_\_\_\_\_ Physician: \_\_\_\_\_

School: \_\_\_\_\_ Classroom Teacher: \_\_\_\_\_

SLP: \_\_\_\_\_ OT: \_\_\_\_\_ Nurse: \_\_\_\_\_

Medical History: \_\_\_\_\_

## GENERAL INFORMATION

During this consultation the student was:

**Seating**     wheelchair     Tumbleform     Rifton Chair     other \_\_\_\_\_

**Student Position**     upright     semi upright     reclining <30°     other \_\_\_\_\_

**Food Presented by:**     classroom teacher     paraprofessional     parent     other \_\_\_\_\_

**Utensils used:**     bottle     sippy cup     cup     spoon     straw

## GENERAL OBSERVATIONS

**Behavior**     cooperative     resistant     refusal     other \_\_\_\_\_

**Alertness**     alert     lethargic     irritable     other \_\_\_\_\_

**Follows directions**     verbal     gestural     none     single step only

**Vision**     mild impairment     moderate impairment     severe impairment

## GENERAL PHYSICAL OBSERVATIONS

**Abnormal reflexes observed:** \_\_\_\_\_

**Trunk Control**     adequate     excessive extension     dystonia     scoliosis     kyphotic

**Head Control**     adequate     poor     excessive head/neck hyperextension

receives external positioning     receives manual positioning     reflexive position patterns

**Facial**     asymmetrical     contortions     jaw extension     grimaces/tics

open mouth posture     increase tone     decrease tone

**Breathing Patterns**     mouth breather     audible inhalation

## OBSERVATION OF FEEDING

**Food Consistencies**     pureed     mashed     semi-solid     chopped     bite size

mixed (indicate consistencies of mixtures)  solid

## FEEDING MILESTONES ATTAINED BY STUDENT:

\_\_\_\_\_ strained foods (4-6 mos.)    \_\_\_\_\_ regular table foods (18-24 mos.)

\_\_\_\_\_ junior foods (6-10mos.)    \_\_\_\_\_ cup drinking (12 mos.)

\_\_\_\_\_ chopped foods (10-12mos.)    \_\_\_\_\_ discontinued bottle use (18 mos.)



## TYPE AND SEVERITY OF DYSPHAGIA

### ***Oral Preparatory Phase:***

Loss of food/liquid from the oral cavity due to reduced/poor lip closure

Inadequate mastication (i.e., chewing) of bolus due to reduced strength, range of motion, and/or coordination of mandibular (i.e., jaw), lingual (i.e., tongue) structures or reduced sensation in the oral cavity

Poor bolus formation secondary to reduced strength, range of motion, and/or coordination of lingual structure or reduced sensation in the oral cavity

Stasis (i.e., food residue) evident in the lateral sulcus/sulci (i.e., spaces between the inside of the cheeks and tongue) following the swallow due to reduced strength of buccal (i.e., cheeks) structure

Stasis evident under the tongue following the swallow due to reduced strength of the lingual structure

### ***Oral Phase:***

Loss of food/liquid from the oral cavity due to reduced/poor lip closure

Premature spillage of food/liquid over the tongue base due to reduced strength, range of motion, and/or coordination of the lingual structure or reduced sensation in the oral cavity

Stasis (i.e., food residue) evident in the lateral sulcus/sulci (i.e., spaces between the inside of the cheeks and tongue) following the swallow due to reduced strength of buccal (i.e., cheeks) structure

Stasis evident under the tongue following the swallow due to reduced strength of the lingual structure

Stasis evident on the hard palate following the swallow due to reduced elevation of the lingual structure

Food expelled from the oral cavity due to tongue thrusting

Delayed oral transit time to move the bolus from the anterior oral cavity to the posterior oral cavity

Excessive lingual movement evident during the swallow due to reduced lingual coordination or as a compensatory behavior secondary to a delayed/absent swallow reflex

### ***Pharyngeal Phase:***

Delayed/absent swallow reflex resulting in coughing, choking, or wet vocal quality

Weak/reduced laryngeal elevation resulting in coughing, choking, or wet vocal quality

Regurgitation of food/liquid through the nasal cavity due to insufficient velopharyngeal closure

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# SWALLOWING AND FEEDING PLAN

Student: \_\_\_\_\_ Date of Plan: \_\_\_\_\_  
Teacher: \_\_\_\_\_ Review Date: \_\_\_\_\_  
School: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Dysphagia Case Manager:** \_\_\_\_\_

If there are any questions regarding this student's feeding plan, please contact the Case Manager at the following:

Location(s): \_\_\_\_\_ Phone: \_\_\_\_\_

**Case History:** \_\_\_\_\_

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## Feeding Recommendations:

Positioning: \_\_\_\_\_

Equipment:

cup: \_\_\_\_\_

spoon: \_\_\_\_\_

bowl/plate: \_\_\_\_\_

adaptive equipment/device: \_\_\_\_\_

**Tube Fed:**  tube fed/nothing by mouth  tube and oral fed  
(amount fed orally: \_\_\_\_\_)

## Diet/Food Prep:

Food Consistency  Pureed  Mashed  Chopped

Semi-Solid  Bite sized

Liquid Consistency  No liquids  Thin liquids

Thickened liquids  nectar  honey  pudding

Other: \_\_\_\_\_

## Feeding Plan Techniques/Precautions:

Amount of food per bite: \_\_\_\_\_

Food placement: \_\_\_\_\_

Keep student in upright position \_\_\_\_\_ minutes after meal.

Offer a drink after \_\_\_\_\_ bites

Additional precautions/comments: \_\_\_\_\_

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## Feeding/Swallowing Plan In Service Training

I, the undersigned, have read and been trained on implementing the feeding/swallowing plan for \_\_\_\_\_. I agree to follow the swallowing program as specified.

Name \_\_\_\_\_ Date \_\_\_\_\_

Position \_\_\_\_\_ Review Date \_\_\_\_\_

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