



MONTGOMERY TOWNSHIP SCHOOLS

1014 ROUTE 601 • SKILLMAN, NJ • 08558 • PHONE (609) 466-7601 • FAX (609) 466-0944

Office of Special Services

SPEECH SCREENING REQUEST FORM

Date: _____

Student: _____ DOB: _____

Teacher: _____ Grade: _____

Parent(s): _____ Phone: _____

Parent(s) email: _____ Languages spoken at home: _____

Has your child previously received speech-language services? _____

This form constitutes a request for a speech screening, with parent/guardian permission, to determine if a special education referral is needed. This screening will include a review of the student's speech articulation, fluency or voice. Results will be shared with parent(s) and teacher(s) to determine a plan of action. A copy will be placed in the speech-language specialist's temporary file.

Reason for Screening Request: (check all areas of concern)

- Speech articulation/pronunciation
- Fluency/stuttering
- Voice differences (e.g., hoarseness, hypernasality, pitch, rate, volume)

Comments (Please provide specific examples to support request)

- I **do** give consent to conduct a speech screening.
- I **do not** give consent to conduct a speech screening.

Parent/Guardian Signature

Date

Building Use Only

Date Request Received _____

Date of Screening _____

Speech-Language Specialist _____

Results: Pass Rescreen Referral Recommended

Revised 10/2019