Government of **Western Australia**
Child and Adolescent Health Service

Speech Pathology referral information for children for whom English is an additional language

Child Development Service

Child's Name: _____ **Child's Date of Birth:** _____

Date completed: _____

This checklist should be used to gather additional information **from the parent/guardian in support of a referral** to Speech Pathology at the metropolitan Child Development Service (CDS). It should be accompanied by a CDS referral form containing a description of the child's speech and language skills.

1. Was an interpreter used to obtain this information? ☐ Yes ☐ No

Which language? _____

Who acted as interpreter? (e.g. relative, friend, qualified interpreter, Education Assistant):

_____

2. Has the child been seen by a visiting teacher for ESL? ☐ Yes ☐ No

3. Child's country of origin: _____

4. How long has this child lived in Australia? _____

5. Father's primary language: _____

6. Languages spoken by father to child: _____

7. Mother's primary language: _____

8. Languages spoken by mother to child: _____

9. Languages spoken by significant others (e.g. grandparent, daycare staff):

_____

10. Languages spoken by the child: _____

11. Primary language spoken at home: _____

12. Please comment on the parents' and caregivers' proficiency in English:

13. Please summarise the child's exposure to English (e.g. childcare, playgroup):

We are now interested in getting an idea of the child's skills in their FIRST LANGUAGE compared to their skills in English (second language).

		First Language		English	
		Yes	No	Yes	No
SPEECH	The child's sentences are easily understood				
	The child's speech sounds similar to other children their age				
EXPRESSIVE LANGUAGE	The child is speaking in full sentences				
	The child has difficulty finding the right word to name things				
	The child can tell a story				
COMPREHENSION	The child understands instructions				
	The child can answer a range of questions correctly				
	The child has difficulty attending/listening				

Name: _____

Agency/School: _____

Agency/School address: _____

Agency/School phone number: _____

Email: _____

Please return this checklist and CDS referral form to childdevelopmentservice@health.wa.gov.au

This document can be made available in alternative formats on request for a person with a disability.

February 2022 CAH-1496