

## Speech Therapy Fluency Intervention Form

CHILD'S NAME:	Date Interventions began:
TEACHER'S NAME:	Date Interventions completed:

Directions: *Implement the selected fluency interventions in the student's classroom. Mark (+) or (-) in the box to indicate whether or not the intervention was successful. . (+) indicates the student's speech was smooth, without disfluencies. (-) indicates that the student's speech was not fluent (i.e. bumpy or stuck). Pre-referral interventions must be implemented several times across a minimum of two weeks.*

Fluency Interventions	Date 1	Date 2	Date 3	Date 4	Date 5
Pick a topic to talk with the child about for one minute. (Ideas: favorite game, favorite TV show, favorite movie, family members, friends, vacation, etc.) Slow your own rate of speech during the interaction.					
When you waited patiently, showing interest and did not fill in any words for the student, did you see a difference?					
When you waited patiently, showing interest and did not fill in any words for the student, did you see a difference?					
Did the student exhibit any disfluencies when time pressures were removed?					
Do not ask the student to stop and start over. Accept whatever quality of language is expressed and then give positive regard for the content of the communication.					
Discourage interruptions when the student gets stuck on a work, sound, or sentence.					

Observations:

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Interventions were effective:  Yes  No

Contacted parent(s) regarding concern \_\_\_\_\_(date)

Check one:  by phone  in person  in writing

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

\_\_\_\_\_  
Date

## Speech Therapy Teacher Input-Fluency

Child's Name: \_\_\_\_\_

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

Teacher's Name: \_\_\_\_\_

Grade: \_\_\_\_\_

Your observation and responses concerning the above student will help determine if a fluency 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)

1. Does the student have characteristics associated with stuttering (e.g. part or whole word repetitions, silent blocks, sound or word prolongations)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Are the stuttering characteristics accompanied by other behaviors (e.g. tension in the upper trunk, neck and head, facial tics, body movements)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the stuttering make it difficult to understand the content of his/her speech?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the student appear to talk less in the classroom because of the stuttering?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the student avoid verbal participations during classroom activities?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the student avoid verbal participations in social situations?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you think the student is aware of his/her communication problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have the student's parents talked to you about his/her fluency disorder?	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other observations relating to this student's communication skills?

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It is my opinion that these behaviors:

- DO NOT adversely affect educational performance
- DO adversely affect educational performance

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

\_\_\_\_\_  
Date