**Speech Pathology Referral Form**

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| Date of Referral: | Date Received: |

**Client Details**

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| --- | --- | --- | --- | --- |
| Child’s Name: | | | Male / Female (circle) | |
| Date of Birth: | | | | Age: |
| Parent/Carer’s Name/s: | | | | |
| Address: Postcode: | | | | |
| Phone (h) | (Mob) | (Wk) | | |
| Email Address: | | | | |
| Country of Birth: | | | | |
| Language(s) Spoken by Child: | | | | |
| Language(s) Spoken by Parent/Carers: | | | | |
| Interpreter Required? **Yes No** | | | | |

|  |  |  |
| --- | --- | --- |
| GP Name: | | Phone: |
| GP Address: | | |
| Preschool/Child Care:  Teacher: | Days: M, T, W, Th, F (circle and/or list hours)  Age started: | |

**Reason for Referral:** (Please indicate areas of concern)

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| * Receptive Language (understanding) | * Expressive Language (talking) |
| * Speech Sound Development | * Stuttering |
| * Play/Social Skills | * Attention/Listening Skills |

**Please give more information: (area of concern, relevant medical history, parental perception of problem etc)**

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**Other Referrals:**

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| --- | --- |
| Has the child had their hearing assessed? If yes, where and when and results if known: | **Yes No** |
| Has the child been referred to any other specialists or agencies? If ‘yes’, please specify (e.g. Early Childhood Intervention Services, The Cottage Centre for Families and Children) | **Yes No** |
| If ‘yes’ do parents give permission for the Speech Pathologist to contact those agencies, to notify them of the referral and exchange information relevant to the child’s assessment? | **Yes No** |

**Referral Source:**

|  |  |
| --- | --- |
| Name: | Relation to Child: |
| Profession: | Ph: |
| Address: | |
| Parental/guardian consent for referral given? **Yes No** | |