

**SPEECH AND LANGUAGE SERVICES
 REFERRAL FOR SPEECH AND LANGUAGE ASSESSMENT**

Please Complete Both Pages of this Form

CHILD'S NAME: _____ BIRTH DATE: _____
(FIRST) (LAST) (MONTH / DAY / YEAR)

CHILD'S PERSONAL HEALTH NUMBER: _____ GENDER: _____

ADDRESS: _____ POSTAL CODE: _____
(STREET) (CITY)

TELEPHONE: HOME: _____ WORK: _____ CELL: _____

PARENTS / LEGAL GUARDIANS: _____
(PARENT 1) (PARENT 2)

E-MAIL ADDRESSES _____

LANGUAGE(S) SPOKEN AT HOME: _____ INTERPRETER NEEDED: YES NO

PRESCHOOL / DAYCARE: _____

FAMILY PHYSICIAN: _____ TELEPHONE: _____

DESCRIPTION OF PROBLEM: _____

PERTINENT MEDICAL CONDITIONS: _____

DEVELOPMENT (ANY CONCERNS): _____

FAMILY HISTORY OF SPEECH, LANGUAGE, OR HEARING PROBLEMS: _____

- OTHER AGENCIES PROVIDING SERVICE TO CHILD:
- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> SPEECH LANGUAGE PATHOLOGIST (OTHER) | <input type="checkbox"/> AUDIOLOGIST | <input type="checkbox"/> PEDIATRICIAN |
| <input type="checkbox"/> OCCUPATIONAL THERAPIST | <input type="checkbox"/> PHYSIOTHERAPIST | <input type="checkbox"/> PSYCHOLOGIST |
| <input type="checkbox"/> INFANT DEVELOPMENT PROGRAM | <input type="checkbox"/> SUPPORTED CHILD CARE DEVELOPMENT PROGRAM | |
| <input type="checkbox"/> CENTRE FOR ABILITY | <input type="checkbox"/> OTHER _____ | |

NAME OF REFERRAL SOURCE: _____ SIGNATURE: _____

AGENCY: _____ DATE: _____

PLEASE DESCRIBE YOUR CHILD'S COMMUNICATION BELOW:

DOES YOUR CHILD APPEAR FRUSTRATED BY HIS/HER DIFFICULTY TALKING?

- NEVER SOMETIMES FREQUENTLY

DO STRANGERS HAVE DIFFICULTY UNDERSTANDING YOUR CHILD'S SPEECH?

- NEVER SOMETIMES FREQUENTLY

DOES YOUR CHILD UNDERSTAND QUESTIONS AND FOLLOW DIRECTIONS?

- NEVER SOMETIMES FREQUENTLY

DID YOUR CHILD BABBLE (MAKE A VARIETY OF SPEECH SOUNDS) AS A YOUNG CHILD?

- NEVER SOMETIMES FREQUENTLY

HOW DOES YOUR CHILD USUALLY LET YOU KNOW WHAT HE OR SHE WANTS? CHECK ALL THAT APPLY

- | | | |
|--|---|--|
| <input type="checkbox"/> CRIES | <input type="checkbox"/> USES SOUNDS | <input type="checkbox"/> USES MANY WORDS |
| <input type="checkbox"/> POINTS | <input type="checkbox"/> USES MANY SOUNDS | <input type="checkbox"/> 2 OR 3 WORD SENTENCES |
| <input type="checkbox"/> USES GESTURES | <input type="checkbox"/> USES A FEW WORDS | <input type="checkbox"/> USES LONG SENTENCES |

PLEASE GIVE SOME EXAMPLES OF WHAT YOUR CHILD SAYS:

DEVELOPMENTAL MILESTONES:

AT WHAT AGE DID YOUR CHILD?

SIT ALONE _____ WALK _____ BECOME TOILET TRAINED _____

USE SINGLE WORDS _____ USE 2 OR 3 WORD PHRASES _____

SPEECH & LANGUAGE SERVICES CONSENT

I _____ PARENT/GUARDIAN OF: _____ GIVE PERMISSION
(Parent/Guardian's name) Child's name)

FOR THE SPEECH AND LANGUAGE PROGRAM AT VANCOUVER COASTAL HEALTH NORTH SHORE TO:

1. COMMUNICATE WITH ME ABOUT MY CHILD'S APPOINTMENTS VIA E-MAIL YES NO
2. CARRY OUT AN EVALUATION OF MY CHILD'S SPEECH AND LANGUAGE SKILLS YES NO

SIGNED (PARENT/GUARDIAN): _____ **DATE:** _____

**ACKNOWLEDGEMENT OF THIS REFERRAL WILL BE MADE BY AN EMAIL.
 YOUR CHILD WILL ALSO BE REFERRED TO THE HEARING CLINIC**