Speech and Language Services
NORTH SHORE COMMUNITY HEALTH SERVICES
CENTRAL COMMUNITY HEALTH CENTRE
132 W. ESPLANADE AVE. – 5TH FLOOR.
NORTH VANCOUVER, BC V7M 1A2
TEL: (604) 983-6760; FAX: (604) 983-6839;
EMAIL: nsslp@vch.ca

SPEECH AND LANGUAGE SERVICES
REFERRAL FOR SPEECH AND LANGUAGE ASSESSMENT

Please Complete Both Pages of this Form

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

CHILD'S PERSONAL HEALTH NUMBER: _____ GENDER: _____

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

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:

☐ SPEECH LANGUAGE PATHOLOGIST (OTHER) ☐ AUDIOLOGIST ☐ PEDIATRICIAN
☐ OCCUPATIONAL THERAPIST ☐ PHYSIOTHERAPIST ☐ PSYCHOLOGIST
☐ INFANT DEVELOPMENT PROGRAM ☐ SUPPORTED CHILD CARE DEVELOPMENT PROGRAM
☐ CENTRE FOR ABILITY ☐ OTHER _____

NAME OF REFERRAL SOURCE: _____ SIGNATURE: _____

AGENCY: _____ DATE: _____

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Central Community Health Centre
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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

☐ Cries	☐ Uses sounds	☐ Uses many words
☐ Points	☐ uses many sounds	☐ 2 or 3 word sentences
☐ Uses gestures	☐ Uses a few words	☐ 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