Children's Hearing & Speech Centre of BC

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Speech and Language Program Referral Form

*Please note that this is a private fee for service program that accepts referrals for children from birth to 13 years of age.

* Please send completed forms to kkakar@childrenshearing.ca

*By completing this form, you consent to communication via email and acknowledge that electronic security cannot be guaranteed.

General Information

Referral Date	Client's Name	Client's Primary Language	Date of Birth	Age

Address *(including postal code)*	Home Phone	Sex

Referral Source *(How did you hear about us?)*

- ☐ Internet, specify (FB/ Google/ Website) _____
- ☐ Practitioner's/ Organization Name, specify_____
- ☐ Former/ Current CHSC student
- ☐ Self/ Friends/ Relatives ☐ Other, please specify _____

Languages spoken by client

- ☐ English
- ☐ Other:_____

Parent/Guardian 1	Cell Phone
Work Phone	Email
Parent/Guardian 2	Cell Phone
Work Phone	Email

Reason for Referral

Please check all that apply

- ☐ Specific speech sound errors
- ☐ Few spoken words for age
- ☐ Difficulty forming sentences
- ☐ Grammar
- ☐ Difficulty understanding and responding
- ☐ Learning or literacy difficulties
- ☐ Behavior (e.g., impulsive, aggression, tantrums)
- ☐ Stutters/repeats sounds and words
- ☐ Voice problem (e.g., hoarse voice, nasal sounding)
- ☐ Query Autism
- ☐ Query developmental delay
- ☐ Child has diagnosis of: _____
- ☐ Other: _____

Previous, current, or waitlisted (if known) physicians, specialists, testing, or clinics attended:

- ☐ Autism Assessment
- ☐ Developmental Assessment
- ☐ Ear, Nose and Throat Specialist
- ☐ Pediatrician
- ☐ Infant Development Program/Supported Child Development
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Speech Language Pathologist
- ☐ Audiologist
- ☐ Other: _____

What are your priorities, questions, or concerns?

Referral Returned (office use only)

- ☐ Contacted on _____
- ☐ Appointment booked on _____
- ☐ Added to waitlist No. _____
- ☐ Referred elsewhere _____