Children's Hearing & Speech Centre of BC

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Children's Speech Program Referral Form

*Please note that this is a private pay program that accepts referrals for children from birth to 8 years old.
* Please send completed forms to kgriffith@childrenshearing.ca

*By completing this form you are consenting to communication via email and acknowledge that this may not be secure.

General Information

Referral Date	Referral Source (e.g. mother)	Client's Primary Language	Interpreter Required (specify language) ☐ Yes _____ ☐ No
Client's Name		Date of Birth	Age	Sex ☐ Male ☐ Female
Address *(including postal code)*		Home Phone	
Parent/Guardian		Cell Phone	
Work Phone		Email	
Parent/Guardian		Cell Phone	
Work Phone		Email	

Reason for referral

Please check all concerns that apply:

- ☐ Difficult to understand
- ☐ Specific speech sound errors
- ☐ Few spoken words for age
- ☐ Forming sentences and using grammar
- ☐ Understanding and responding
- ☐ Following directions/auditory skills
- ☐ Learning or literacy
- ☐ Behaviour (e.g. impulsive, aggression, tantrums)
- ☐ Social skills
- ☐ 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
- ☐ Other:_____

What are your priorities, questions or concerns?

Referral Returned (office use only)

- ☐ Confirmed receipt of referral
- ☐ Added to waitlist
- ☐ Information sent to therapist
- ☐ Email address confirmed
- ☐ Case History Sent
- ☐ Case History Returned
- ☐ Contacted to schedule
- ☐ Appointment booked