

# Speech Pathology Referral



This service is for children aged 0-6 years prior to school entry, with a:

- speech delay and speech that is difficult to understand
- language delay and difficulty communicating
- stutter, or
- voice disorder (GP or ENT referral preferred)

*This service is NOT for children with a diagnosed or suspected cognitive and/or developmental delay. They are NOT eligible for this service and should be referred to National Disability Insurance Agency (NDIA) at <http://www.ndis.gov.au/my-access-checker>. If the child is on the waiting list or already accessing services with Gateways, Noah's Ark, Scope or DEECD Specialist Children's, please do not continue with this referral.*

Please return this completed referral form by mail to **Community Health & Rehabilitation Services Information and Access**, 120 Settlement Road Belmont VIC 3216, fax (03) 4215 7795 or email: [chrsinfoaccess@barwonhealth.org.au](mailto:chrsinfoaccess@barwonhealth.org.au)

## CLIENT DETAILS

Child's name: \_\_\_\_\_ Gender: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_  
Parent(s) and/or guardian's name: \_\_\_\_\_  
Phone (home): \_\_\_\_\_ Mobile: \_\_\_\_\_  
Kindergarten and/or child care: \_\_\_\_\_  
School for next year (if relevant): \_\_\_\_\_  
Other medical or educational services the child accesses: \_\_\_\_\_  
• Aboriginal or Torres Strait Islander • Refugee • Homeless/ at risk of homelessness

## REFERRER DETAILS

Name: \_\_\_\_\_ Profession: \_\_\_\_\_  
Agency: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Please provide details of pre-referral screening assessment conducted on \_\_\_\_\_  
• Brigance • Kinder Screening Tool  
• Communication and Symbolic Behavioural Scales Developmental Profile • Other:  
Please describe your concerns regarding the child's communication skills:  
\_\_\_\_\_



Do you have **any other** concerns regarding the child's development (e.g. drawing, using scissors, play, toileting, learning, behaviour, socialisation, climbing, running)? Yes/No

*If you answered **yes** to the above, please refer to **NDIA only** as this referral would not be appropriate for Community Health.*

Barwon Health provides a paediatric speech pathology service through the local community health centres located at:			
Belmont Community Health 1-17 Reynolds Road	Corio Community Health 2 Gellibrand Street	Newcomb Community Health 104-108 Bellarine Highway	Torquay Community Health 100 Surfcoast Highway

**PARENTAL/GUARDIAN CONSENT**

As the authorised representative of this child, I \_\_\_\_\_ (name) consent to a referral to Barwon Health Information and Access Services for Speech Pathology. I understand that Barwon Health Information and Access Service may discuss the information contained in this form with relevant health professionals in order to provide the most appropriate services for my child:

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Verbal Consent:** Yes/No

As the authorised representative of this child, I \_\_\_\_\_ (name) consent for the Speech Pathologist to inform the referrer of the assessment outcome and any other feedback relating to my child's communication concerns. I understand that I can choose to decline this consent at any stage by notifying the Speech Pathologist verbally or in writing.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Verbal Consent:** Yes/No



**Referring Agent (e.g. Kindergarten Teacher, MCHN) please to complete the relevant sections of this questionnaire:**

<b>Stuttering / Fluency</b>	
<i>Is the child stuttering?</i>	
• Has the child been stuttering for more than 3 months?	Yes/No
• Is there a family history of stuttering?	Yes/No
• Is the parent concerned about the stutter?	Yes/No
• Is the child attending Primary School next year?	Yes/No
Other comments:	
<b>Language</b>	
<i>Is the child having difficulty talking or saying sentences?</i>	
• Is the child exposed to a language other than English? Please detail:	Yes/No
• Do you feel the child should be understanding more for their age? (e.g. understanding routines and following instructions)?	Yes/No
• Do you feel the child should be able to say more for their age? (e.g. answering simple questions?)	Yes/No
• How many words is the child saying? (please circle) Less than 10      Less than 25      Less than 50      About 100+	
Other comments:	
<b>Speech</b>	
<i>Is the child unclear or have difficulty saying sounds when they talk?</i>	
• Is the child's speech pronunciation understood by others?	Yes/No
• Does the child have difficulty saying lots of different sounds?	Yes/No
• Does the child only have difficulty with 'S', saying it like a "Th" so a word such as "sink" would be "think" or their 'S' sounds slushy (That is, only have a lisp) ?	Yes/No
• Are there any concerns with the child's teeth?	Yes/No
Other Comments:	
<b>Voice</b>	
<i>Is the child having difficult with their voice?</i>	
• Does the child speak too loudly or too softly?	Yes/No
• Does the child have a husky or hoarse sounding voice?	Yes/No
• Does the child have a nasal sounding voice (e.g. like have a cold)?	Yes/No
Other Comments:	
<b>Social</b>	
<i>Is the child having difficult with social interaction?</i>	
• Does the child make eye contact when communicating	Yes/No
• Does the child engage in two-way conversation?	Yes/No
• Does the child have an intense interest in in certain objects or activities (e.g. only play with trains)	Yes/No
• Does the child communicate with adults (with support), but not with peers?	Yes/No
• Does the child engage in pretend play (e.g. pretend feeding a teddy)?	Yes/No
Other Comments:	

