Bendigo Health Paediatric Speech Pathology and Audiology Referral Form

Date of referral/s	Click here to enter a date.

Referral/s required (Please tick)	
☐	Speech Pathology – Community Health Outpatients
☐	Speech Pathology – Swallowing Disorders Clinic
☐	Audiology (Hearing Test)

Child details

First name		Last name	
Date of birth		Gender identity	
Home address			
Refugee status	YES / NO	Does the child identify as Aboriginal and/or Torres Strait Islander?	YES / NO
Does the child live with their parents?	YES / NO	If no, please provide details of living arrangements:	
Are there any court orders / custody arrangements for the child?	YES / NO		
Does the carer have a family health care card?	YES / NO		
What is the child's Medicare Card number?	_ _ _ _ _ _ _ _ _ _ / _		
What year will the child start school? (if known)			

Carer details

Adult 1: Name			
Relationship to child		Preferred language	
Address			
Phone number		Email	
Adult 2: Name			
Relationship to child		Preferred language	
Address			
Phone number		Email	

Language

Main language spoken at home (including Auslan):		
Is an interpreter required? (Please list language)	YES / NO	

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Referrer details	
Name	
Profession	
Organisation	
Address	
Phone	
Email	

Reason for referral

What are the carer/s main concerns for their child?
Have there been any stresses, trauma or changes in the family in the last few years (e.g. separation, moving house, death of a relative, DHHS involvement, unemployment, depression etc?)
Are there any concerns about the safety of the child or family?

Is the child currently receiving services anywhere else?	If Yes, where?	YES / NO
Has the child been referred to other services?	If Yes, where?	YES / NO
Has the child had a hearing assessment?		YES / NO

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Does the child have difficulty with:

(Please indicate if there are concerns in each of the main headings. If yes, tick all relevant items in the box)

Understanding Language (Receptive Language) YES / NO

☐ Following instructions
☐ Learning basic concepts (e.g. names, objects, colours)
☐ Understanding conversation
☐ Needs information to be consistently repeated
☐ Listening and maintaining attention
☐ Difficulty identifying objects and pictures
☐ Difficulties responding to their name

Using Language (Expressive Language) YES / NO

☐ Gestures / babbling only
☐ Singe words only
☐ 2 word combinations
☐ Sentences of 3 or more words

Speech Sounds (Articulation) YES / NO

☐ Difficulty with a few sounds
☐ Becoming distressed if they are not understood
☐ Difficulty with many sounds
☐ Others have difficulty understanding the child

Stuttering YES / NO

☐ Stuttering for more than 12 months
☐ Repeats sounds / words / phrases
☐ Is frustrated by the stuttering

Voice YES / NO

☐ Persistently hoarse / husky voice
☐ Periods of no voice

Feeding / Swallowing YES / NO

☐ Coughing when eating and drinking
☐ Choking / Gagging when eating or drinking
☐ Fussy eating
☐ Enteral feeing (NGT, PEG, NJT)
☐ Difficulty managing saliva / Excessive drooling
☐ Difficulty transitioning to solid foods
☐ Associated weight loss or weight concerns

Hearing YES / NO

☐ Describe concerns about hearing/urgency for assessment: _____

☐ Syndromes and / behavioural concerns: _____

Other concerns or additional information:

Consent

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Do you consent to the collection and sharing of the information contained in this form as outlined above?			
☐	YES I consent to the collection and sharing of the information contained in this form **(This is required)**		
☐	Verbal consent		
Written Consent			
Carer Name			
Signature		Date	Click here to enter a date.
Referrer Signature		Date	Click here to enter a date.

If you have any questions or queries filling out the referral form please contact the Allied Health Reception on **5454 8783 (option 3).**

DO NOT send the referrals to the Speech Pathologists / Audiologists directly. Please send ALL referrals to the Bendigo Health Referral Centre.

Fax: 5454 7099

Mail: Bendigo Health Referral Centre
PO Box 126
Bendigo VIC 3552