|  |  |
| --- | --- |
| 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 |  |

|  |
| --- |
| 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 |

|  |
| --- |
| 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  |
| 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

**Email:** ReferralCentre@bendigohealth.org.au

**Mail:** Bendigo Health Referral Centre

PO Box 126

Bendigo VIC 3552