|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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](mailto:ReferralCentre@bendigohealth.org.au)

**Mail:** Bendigo Health Referral Centre

PO Box 126

Bendigo VIC 3552