Outpatient Speech-Language Pathology Referral

☐ James Paton Memorial Regional Health Centre
125 Trans Canada Highway
Gander, NL A1V 1P7
Phone: (709) 256-5458 Fax: (709) 256-5780

☐ Central Newfoundland Regional Health Centre
50 Union Street
Grand Falls-Windsor, NL A2A 2E1
Phone: (709) 292-2169 Fax: (709) 292-2355

Name: _____ Date of Referral: _____
Date of Birth: _____ Referral Source: _____
Address: _____ Family Physician: _____
_____ MCP: _____
Next of Kin: _____ Phone: _____

1. Please check ALL that apply.

Speech

Difficulty:
- ☐ Pronouncing words/sounds
- ☐ Being understood by others

Social Skills
- ☐ Behavior problems
- ☐ Poor eye contact

Difficulty:
- ☐ Listening or paying attention
- ☐ Playing/interacting with peers

Feeding/Swallowing
- ☐ Experiences coughing/choking when eating/drinking

Difficulty:
- ☐ sucking ☐ chewing
- ☐ swallowing

Language

Difficulty:
- ☐ Understanding what you say
- ☐ Following directions
- ☐ Organizing and expressing ideas
- ☐ Communicating effectively with others

Uses:
- ☐ limited vocabulary
- ☐ immature grammar

Stuttering/Fluency
- ☐ Repeats whole or parts of words
- ☐ "Gets stuck" on words or sounds

Voice
- ☐ Loss of voice
- ☐ Hoarseness/Breathiness
- ☐ Other_____

2. Additional Information

a. Is the patient/caregiver concerned about communication? ☐ Yes ☐ No

b. Please list other services the patient is receiving/has received.

_____
_____
_____

c. Please provide any relevant information (e.g., medical history, behavioral observations, etc.).

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