JAMES COOK UNIVERSITY AUSTRALIA

JCUHealth Speech Pathology

Level 1, Clinical Practice Building
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James Cook University QLD 4811

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JCU Speech Pathology Clinic

Adult Referral Form

Please email, fax or deliver the completed form using the details above.

Date of Referral: _____

Client's Details:

Name: _____ Date of Birth: _____

Home Address: _____

_____

Email: _____

Home phone: _____ Can we leave a message at this number? YES/NO

Mobile phone: _____ Can we leave a message at this number? YES/NO

Are you listed on a health care or pension card?

☐ Yes, health care card ☐ Yes, pension card ☐ No, neither

Occupation: _____

Highest level of education: _____

Primary Medical Practitioner _____ GP/Specialist (please circle)

Medical Practitioner Address _____

_____

Medical Practitioner Phone: _____ Fax: _____

Is an Enduring Power of Attorney (EPOA) for health currently responsible for making health decisions on your behalf? YES / NO

If yes, please complete the following with the EPOA holder's details.

Name: _____

Relationship to client: _____

Home Address (if different to the clients): _____

_____

Email: _____

Home phone: _____ Can we leave a message at this number? YES/NO

Mobile phone: _____ Can we leave a message at this number? YES/NO

Reason for Referral:

Please describe the difficulties you are having that have lead you to access this clinic.

_____

_____

_____

_____

_____

_____

_____

_____

What are your main priorities/goals at this time?

_____

_____

_____

_____

Diagnosis:

Have you received a medical diagnosis (e.g. stroke, TBI, dementia, Parkinson's etc.)?

YES / NO

If yes, please specify: _____

If yes, when was the diagnosis received? _____

Previous Services

Are you receiving services from another allied health provider? (e.g. occupational therapy, physiotherapy, psychology)

YES / NO

If yes, please specify: _____

Have you accessed any other allied health services in the past? (e.g. Qld Health, Disability Services, private therapists, etc).

YES / NO

If yes, please specify: _____

Client or EPOA for health to tick applicable boxes to indicate consent. If you do not wish to consent, please leave boxes blank. Please be aware that you are able to change your consents at any time by contacting the clinic.

CONSENT TO SERVICES:

- ☐ I consent to the above named client receiving speech pathology assessment and intervention services from James Cook University
- ☐ I consent to the above named client receiving services provided by JCU speech pathology students under the direct supervision of fully qualified and registered speech pathologists.
- ☐ I understand that if I fail to attend 3 appointments with without notifying the clinic beforehand, no further appointments will be offered.

CONSENT TO DVD RECORDINGS:

- ☐ I consent to clinic sessions being recorded for individual student viewing and learning.
- ☐ I consent to the use of clinic session recordings being used within the Discipline of Speech Pathology for educational and demonstration purposes in lectures, tutorials and practical sessions for speech pathology students. I understand that identifying information related to these recordings will be kept confidential.
- ☐ I consent to Speech Pathology students copying segments of DVD recordings for inclusion in their student portfolio as evidence of professional skills.
- ☐ I consent to being involved in promotion of the JCU Speech & Language Clinic including photographs, quotes and interviews with the press.

CONSENT TO EXCHANGE OF INFORMATION:

I consent to the JCU Speech and Language Clinic exchanging information related to assessment and intervention for the above named client with the above and below named agencies (provide details & sign, as applicable):

_____

_____

Signature: _____

Name: _____

Relationship (Self/EPOA): _____ Date: _____