JAMES COOK UNIVERSITY AUSTRALIA

JCUHealth Speech Pathology

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JCU Speech Pathology Clinic

Paediatric Referral Form

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

Date of Referral: ___________________________

Child's Details:

Name: ____ Date of Birth: ________________

Home Address: ____

____

Parent/Guardian's Details:

Parent/Guardian 1

Name: ____

Occupation: ____

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

Parent/Guardian 2

Name: ____

Occupation: ____

Home Address (if different from child's): ____

____

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

School/Day Care: ________________________________ **Grade** ___________

Reason for Referral:

Please tick the area/s that best describes the reasons for concern for your child (you may select more than one):

- ☐ Speech sound production errors (e.g. says “tup” instead of “cup”)
- ☐ Difficulty following directions at home or at school
- ☐ Difficulty expressing needs or opinions
- ☐ Limited vocabulary
- ☐ Difficulty concentrating or attending to school work
- ☐ Has been diagnosed with Auditory Processing Disorder
- ☐ Stuttering
- ☐ Social skills problems that is, difficulty interacting with adults or peers/making friends and/or maintaining friendships
- ☐ Does not seem to be communicating as well as others of the same age
- ☐ Difficulties with spelling or reading
- ☐ Demonstrating frustrated behaviours due to difficulty communicating or understanding
- ☐ Fine motor skills (e.g. drawing, pencil grip, cutting)
- ☐ Gross motor skills (e.g. running jumping, skipping)
- ☐ Self-help skills (e.g. dressing, toileting, brushing teeth)
- ☐ Sensory differences

What are your main priorities/goals at this time?

____

____

____

____

What are your child’s main strengths and interests?

____

____

____

____

Diagnosis:

Has your child received a medical diagnosis of any disorder, disability or syndrome?

YES /NO

If yes, please specify: ____

If yes, when was the diagnosis received? _____________________________________

Previous Services

Is your child receiving services from another allied health provider? (e.g. occupational therapy, physiotherapy, psychology)

YES / NO

If yes, please specify: ____

Has your child accessed any other allied health services in the past? (e.g. Qld Health, Disability Services, private therapists, Department of Education).

YES / NO

If yes, please specify: ____

Has your child had a hearing assessment?

YES / NO

Date: _______________________Was the hearing within the normal ranges? YES / NO

If no, please specify: ____

Has your child had a vision assessment?

YES / NO

Date: _______________________Was the vision within the normal ranges? YES / NO

If no, please specify: ____

CONSENT TO SERVICES:

Parent/Guardian 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.

☐ I consent to the above named child receiving speech pathology assessment and intervention services from James Cook University.

☐ I consent to the above named child 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 my child with the above and below named agencies (provide details & sign, as applicable):

____

____

____

Signature: ____

Name: ____

Relationship to child: ____

Date: ____