HM Speech Referral Form

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| **Section A:** | | | |
| Name of Client: |  | DOB: |  |
| Address: |  | Who the client lives with: |  |
| Next of kin/Carer: |  | Phone number of Next of kin/carer: |  |
| Name of person referring & their relationship to client: |  | Phone/email of person referring: |  |
| Mobility (how does the person move around e.g. wheelchair, walking stick): |  | Language spoken at home: |  |
| Please list any relevant medical history/diagnoses we should be aware of: |  | | |
| **Section B:** | | | |
| Reason for referral/current concerns (please describe the type of difficulty your client is having here in as much detail as possible) |  | | |
| Goals for speech pathology e.g. improve speech sounds, improve swallowing (please describe the type of difficulty your client is having in as much detail here as possible) |  | | |
| **Section C: Please complete this if you have funding for the client to support speech pathology visits** | | | |
| NDIS  NDIS Number  Plan Manager Name & Contact  Amount of Funding  Private Health Fund  (if speech pathology is covered)  DVA  DVA Gold Card Number  Home Care Package  Provider  Contact Person & number  Medicare Chronic Disease Plan (please forward on the paperwork from your GP) |  | | |
| **Section D: If your client is a child please complete the section below** | | | |
| Tell us a little bit about their interests (personality, what they like/dislike, hobbies and interests) |  | Do they go to school? If so, what year are they in & where? |  |
| Length of pregnancy (weeks) (if your child is aged 5 or under): |  | Has your child had a recent hearing test? If so, what were the results? |  |
| Did your child have any difficulties feeding? If yes please describe. |  | | |
| Please write any additional details about family history here. |  | | |
| **Section E:** | | | |
| Any additional information you would like to add. |  | | |

Please email this form to: [reception@hmspeech.com.au](mailto:reception@hmspeech.com.au)