

Date received:
Office use only

SPEECH PATHOLOGY ADULT REFERRAL FORM

Client Information

Client Name: _____ Date of Birth: _____ Male Female
Home Address: _____
Postal Address (*If different to above): _____
Home Phone: _____ Mobile: _____
Cultural Background: Aboriginal & TSI Caucasian Other Primary Language Spoken: _____
Presenting issue / main concern: _____ Duration: _____

Medical Information

Regular GP: _____ GP Clinic: _____
Relevant Medical History: _____

Ongoing / Previous Involvement of Specialist Clinicians, (e.g. Paediatrician): _____
Ongoing / Previous Allied Health Involvement, (e.g. Physiotherapist): _____

Other Services

Other Agency Involvement: Royal Far West / Mackillop Rural Community Services (REACH) / Other: _____
Is the child being supported by: FaCS / Kinship Care / Other, e.g. 'Brighter Futures' _____
Case Manager / Social Worker Details (*If applicable to child):
Name: _____ Organisation: _____ Phone: _____

*Please note: If this person is cognitively unable to make their own informed medical decisions, the next of kin/guardian must be notified to obtain consent for this referral to be made.

Emergency Contact Information (Next of Kin/Guardian)

Name: _____
Relationship: _____
Address: _____
Phone: _____

Referrer Information

Referring person: _____
Profession: _____
Organisation: _____
Phone: _____
Postal address: _____

Please tick any areas the client is having difficulties with:

*Please note: If this is an URGENT referral, please phone the Bourke office to ensure that this referral has been received and the relevant Allied Health Practitioners have been notified.

Urgent:

- Palliative care
- Swallowing issues

Chronic Disease/Conditions:

- Cardiovascular Disease
 - Hypertension
- CVA
- Dementia
 - Date of diagnosis _____
- Neurodegenerative Disease _____
- Other: _____

Speech and Language:

- Motor Speech (speech production)
- Expressive language (talking and using sentences)
- Receptive language (understanding and following directions)
- Stuttering
- Voice (husky, nasal, strained, hoarse)
- Other (laryngectomy, tracheostomy)

Diet and Feeding:

- Poor nutrition/dietary concerns
- Overweight
- Underweight
- Nil by mouth
- Modified Diet
 - Fluid:
 - Mildly thick (nectar consistency)
 - Moderately thick (honey consistency)
 - Extremely thick (pudding consistency)
 - Food:
 - Soft
 - Minced and moist
 - Smooth pureed

From the above categories please describe your main concerns and how they impact on the client's overall participation levels:

Client Consent:

Referral to Outback Division of General Practice, Speech Pathology Department will not be processed without the consent of the client or next of kin/guardian.

1. I give permission for this referral to be discussed among the members of the Allied Health Department at Outback Division of General Practice and if necessary, to allocate to the other relevant discipline(s) as required.
2. I understand that personal information regarding the reason for my referral may be shared with other care providers that work in association with Outback Division of General Practice. All information held is strictly confidential and I give permission for these health professionals to access this information solely for the purposes of this referral.
3. I give permission to be contacted on the phone number listed above to discuss this referral in further detail. In the instance that I cannot be contacted on the personal number provided on this referral form, I give permission for the Outback Division of General Practice to contact either the referrer, regular GP or other agency to obtain updated personal contact details for myself.
4. I give permission for the Allied Health Team to access relevant medical information regarding myself to assist with the assessment and intervention process.

Name: _____

Signature: _____ Date: _____

Verbal consent provided to: _____

PRIVACY STATEMENT

NSW Outback Division of General Practice (NSW ODGP) is collecting your personal information to enable appropriate health services to be provided to you.

Your personal health information held either in paper or electronic format may be used by this health service, or disclosed outside the health service, to enable appropriate health services to be provided to you.

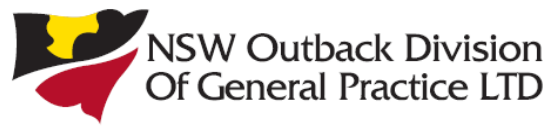
If you do not wish for us to collect, use or disclose certain information about you, you will need to tell us and we will discuss with you any consequences this may have for your health care. If you do not provide the information requested, we may be unable to provide you with the most appropriate services.

Your information will not be passed outside of Australia. Our Privacy Policy contains information about how you may access, update and correct personal information we hold about you, and if you are concerned about how we have handled your information, how to lodge a complaint and how we deal with such complaints.

Please return this referral form by FAX: **02 6872 4888**

OR

POST: **Speech Pathology Department**



NSW Outback Division of General Practice
PO Box 10,
Bourke NSW 2840