NSW Outback Division Of General Practice LTD

Date received:
Office use only

SPEECH PATHOLOGY PAEDIATRIC 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: _____

Parent / Caregiver Information

Name: _____

Relationship to Child: _____

Contact Details - Same as Above: Yes / No

Referrer Information

Referring person: _____

Profession: _____

Organisation: _____

Postal address: _____

Please tick any areas the client is having difficulties with:

Speech and Language:

- ☐ Non-verbal communicator or uses few words
- ☐ Speech is not understood by most listeners
- ☐ Articulation difficulties effecting clear production of speech sounds, for example a lisp
- ☐ Expressive Language
  - ☐ Talking using words and sentences
  - ☐ Story Telling
- ☐ Receptive Language
  - ☐ Understanding words and sentences
  - ☐ Following Instructions
  - ☐ Vocabulary and concept knowledge
- ☐ Difficulties communicating socially
- ☐ Stuttering for longer than 6 months
- ☐ Voice (hoarse, husky, nasal, strained)

Diet and Feeding:

- ☐ Swallowing difficulties
- ☐ Modified diet (food)
- ☐ Modified fluids
- ☐ Fussy eating
- ☐ Nil by mouth
- ☐ Poor nutrition/dietary concerns
- ☐ Breastfeeding
- ☐ Starting solids

General skills:

- ☐ Attention & concentration
- ☐ Following routine
- ☐ Behaviour
- ☐ Ability to sit at a desk
- ☐ Copying from the board
- ☐ Play skills
- ☐ Problem solving
- ☐ Interacting with other kids
- ☐ Following instructions
- ☐ Self-care: toileting/dressing/grooming

Social Emotional:

- ☐ Self-esteem/bullying
- ☐ Stress/anxiety/depression
- ☐ Trauma (past/present)

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

Parent/Caregiver Consent:

Referral to Outback Division of General Practice, Speech Pathology Department will not be processed without the consent of the child's parent/caregiver.

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 child's 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 or school information regarding my child to assist with the assessment and intervention process.
5. I give permission for my child's preschool or school teacher to provide renewed consent on my behalf for the Allied Health Professional(s) to see my child for assessment and intervention purposes should the original referral date (as indicated on this form) lapse before my child is seen.

Name:_____ Relationship to Child: _____

Signature: _____ Date: _____

☐ Verbal consent provided to: _____

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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