|  |  |
| --- | --- |
| Date of referral/s  | Click here to enter a date. |
| Referral/s required (Please tick) |
|[ ]  Speech Pathology – Community Health Outpatients  |
|[ ]  Specialist Paediatric Feeding Clinic  |
|[ ]  Audiology (Hearing Test)  |
| Child details |
| First name |  | Last name |  |
| Date of birth |  | Gender identity |  |
| Home address |  |
| Refugee status | YES / NO | Does the child identify as Aboriginal and/or Torres Strait Islander? | YES / NO |
| Does the child live with their parents? | YES / NO | If no, please provide details of living arrangements: |
|  |
| Are there any court orders / custody arrangements for the child? | YES / NO |  |
| Does the carer have a family health care card?  | YES / NO |  |
| What is the child’s Medicare Card number? | \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ / \_ |
| What year will the child start school? (if known) |  |
| Carer details |
| **Adult 1**: Name |  |
| Relationship to child |  | Preferred language |  |
| Address |  |
| Phone number |  | Email |  |
| **Adult 2**: Name |  |
| Relationship to child |  | Preferred language |  |
| Address |  |
| Phone number |  | Email  |  |
| Language |
| Main language spoken at home (including Auslan): |  |
| Is an interpreter required? (Please list language) | YES / NO |  |

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| Referrer details  |
| Name |  |
| Profession  |  |
| Organisation  |  |
| Address  |  |
| Phone |  |
| Email  |  |
| Reason for referral  |
| What are the carer/s main concerns for their child? |
|  |
| Have there been any stresses, trauma or changes in the family in the last few years (e.g. separation, moving house, death of a relative, DFFH involvement, unemployment, depression etc?)  |
|  |
| Are there any concerns about the safety of the child or family?  |
|  |
| Is the child currently receiving services anywhere else? If Yes, where?  | YES / NO |
|  |
| Has the child been referred to other services? If Yes, where? | YES / NO |
|  |
| Has the child had a hearing assessment?  | YES / NO |

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| Areas of Difficulty (Please circle ‘Yes’ or ‘No’ to indicate if there are concerns under each of the main headings. If yes, tick all specific areas of difficulty in the boxes below). |
| Understanding Language (Receptive Language)  | YES / NO |
| [ ]  Difficulty following instructions [ ]  Difficulty learning basic concepts (e.g., names, objects, colours)[ ]  Difficulty understanding conversation [ ]  Needs information to be consistently repeated [ ]  Difficulty responding to their name [ ]  Difficulty identifying objects and pictures[ ]  Difficulty listening and maintaining attention  |
| Using Language (Expressive Language)  | YES / NO |
| [ ]  Not yet using gestures and/or babbling [ ]  Not yet using single words[ ]  Not yet combining words [ ]  Difficulty with sentences of 3 or more words |
| Speech Sounds (Articulation)  | YES / NO |
| [ ]  Difficulty with a few sounds [ ]  Becoming distressed if they are not understood[ ]  Difficulty with many sounds [ ]  Others have difficulty understanding the child |
| Stuttering  | YES / NO |
| [ ]  Stuttering for more than 12 months [ ]  Repeats sounds / words / phrases[ ]  Is frustrated by the stuttering |
| Voice  | YES / NO |
| [ ]  Persistently hoarse / husky voice [ ]  Periods of no voice |
| Feeding / Swallowing  | YES / NO |
| Refer to Community Health Speech Pathology if the child presents with: | Refer to Specialist Paediatric Feeding Clinic if the child presents with: |  |
| [ ]  Difficulty transitioning to solid foods [ ]  Choking / Gagging when eating or drinking [ ]  Fussy eating [ ]  Difficulty managing saliva / excessive drooling (please consider concurrent referral to GP)  | [ ]  Enteral feeding (NGT, PEG, NJT)[ ]  Ex-prem babies establishing bottle feeds [ ]  Babies with feeding problems with associated medical complexities (e.g., cardiac or respiratory presentations)[ ]  Babies or children with feeding issues *and* associated weight problems (that may need dietician input)[ ]  Babies or children with severe allergies effecting feeding outcomes (that may need dietician input)  |
| Hearing  | YES / NO |
| [ ]  Describe concerns about hearing/urgency for assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Syndromes and / behavioural concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other concerns or additional information: |
|  |
| Consent  |
| Do you consent to the collection and sharing of the information contained in this form as outlined above? |
|[ ]  YES I consent to the collection and sharing of the information contained in this form **(This is required)**  |
|[ ]  Verbal consent  |
| **Written Consent**  |
| Carer Name |  |
| Signature |  | Date | Click here to enter a date. |
| Referrer Signature |  | Date | Click here to enter a date. |

If you have any questions or queries filling out the referral form please contact the Allied Health Reception on **5454 8783.**

**DO NOT send the referrals to the Speech Pathologists / Audiologists directly. Please send ALL referrals to the Bendigo Health Referral Centre.**

**Fax:** 5454 7099

**Email:** ReferralCentre@bendigohealth.org.au

**Mail:** Bendigo Health Referral Centre

PO Box 126

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