FNH031272

Northern Health

PAEDIATRIC SPEECH PATHOLOGY REFERRAL FORM (EXTERNAL)

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER:

SURNAME:

GIVEN NAME:

DATE OF BIRTH: SEX:

☐ 3 points of identification checked

Referral criteria:

- For **preschool children** (prior to school entry). Referrals for stuttering and voice issues will not be accepted.
- For preschool children who do not have access to longer-term services (e.g. approved for National Disability Insurance Scheme (NDIS), Early Childhood Early Intervention (ECEI) funding or Community Health (CH).
- The paediatric speech pathology service at Northern Health is only a **short-term service**. We encourage referrals to longer-term services (e.g. NDIS, ECEI, CH) as soon as possible.
- For children living within the **northern catchment** area including Hume City, Whittlesea City & Mitchell Shire Councils.

***All sections of this form MUST be completed or the referral will be rejected.**

☐ **I confirm this child meets the above referral criteria**

Child Details:	
First Name:	**Last Name:**
D.O.B:	Sex: ☐ Male ☐ Female ☐ Other: ☐ Prefer not to say
Address:	**Child lives with:** ☐ Both Parents ☐ Other:
Year expected to start school:	**Does the child have Medicare?** ☐ Yes ☐ No
Is the child an Australian Citizen? ☐ Yes ☐ No If no, Visa sub category:	**Is the child Aboriginal or Torres Strait Islander?** ☐ Neither ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander
Are there any custody issues or court orders in place: ☐ Yes ☐ No **If yes, please attach a copy of court order to this referral*	**Is there Child Protection or Child First involved?** ☐ Yes ☐ No ☐ Previously

BIRTH/ MEDICAL HISTORY (e.g. birth complications, general health, hospital admissions, medications / allergies etc.):

Parent/s Details:		
Caregiver / Parent 1:	**Name:**	**Relationship:**
	Address:	**Phone:**
	Language(s): ☐ English ☐ Other:	**Interpreter required:** ☐ Yes ☐ No
	Country of Birth:	**Email:**
Caregiver / Parent 2:	**Name:**	**Relationship:**
	Address:	**Phone:**
	Language(s): ☐ English ☐ Other:	**Interpreter required:** ☐ Yes ☐ No
	Country of Birth:	**Email:**

Professionals/Services Involved:	
Audiology: **Please refer for a hearing assessment if this has not already been completed.*	**Vision:**
☐ Yes → Date:	☐ Yes → Date:
Outcome → ☐ Normal ☐ Other:	Outcome → ☐ Normal ☐ Other:
☐ No	☐ No
☐ Referred / Awaiting	☐ Referred / Awaiting

HEALTH

NORTHERN

PAEDAITRIC - SPEECH PATHOLOGY REFERRAL FORM

031272

Updated Date: 27/10/2020

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Northern Health **PAEDIATRIC SPEECH PATHOLOGY REFERRAL FORM (EXTERNAL)**	AFFIX PATIENT IDENTIFICATION LABEL HERE U.R. NUMBER: SURNAME: GIVEN NAME: DATE OF BIRTH: SEX:

Continue Professionals/Services Involved	
Kindergarten / childcare: ☐ Yes ☐ No	**Paediatrician:** ☐ Yes ☐ No ☐ Previous
Centre name:	**Name:**
Centre number:	**Service:**
Teacher:	**Contact:**
Does the child have NDIS funding? **Please note that this referral **will not** be accepted if the child has been approved for NDIS funding.* ☐ Yes ☐ No	**Others involved** (e.g. GP, MCHN, Specialists, Speech Pathologist):

Reason for Referral:
Why are you referring the child for a Speech Pathology assessment? * *Please describe*

Does the child have any other areas of developmental concern? **Please tick all areas below that apply to the child*	
☐ **Interacting with others** (E.g. making eye-contact, not always responding to their name etc.)	☐ **Play** (E.g. no pretend play, need help to use toys appropriately etc.)
☐ **Physical** (E.g. rolling, sitting, crawling, walking and using their hands or fingers etc.)	☐ **Activity Levels** (E.g. climbing on furniture, requiring constant supervision etc.)
☐ **Behaviour** (E.g. tantrums, upset with changes of routine etc.)	☐ **Eating/meal times** (E.g. coughing or choking on food or drink, eats a limited range of food or textures, not feeding themselves, needing distractions such as the TV or phone to eat etc.)
☐ **Daily activities** (E.g. difficulty getting dressed, toilet training, poor sleep etc.)	☐ **Going out in the community** (E.g. will run off, will get upset with loud noises etc.)
☐ **Attention** (E.g. difficulty staying still, difficulty focusing on activities, difficulties learning new skills etc.)	☐ **Sensory** (E.g. dislikes haircuts, upset with certain clothing, dislikes messy hands, does not touch certain textures, upset with loud noises etc.)

Have you identified more than one area of concern above?	
☐ **YES:** Refer to **NDIS Early Childhood Early Intervention (ECEI)** at the same time you make this referral.	☐ **NO:** *(i.e. only one area of need has been identified)* Refer to a **longer-term community health service** at the same time you make this referral.
I have referred to: ☐ NDIS ☐ ECEI ☐ Longer-term Community Health	

Referrer Details:	
Referrer Name:	**Position / Agency:**
Date of referral:	**Address:**
Email:	**Phone Number:**

☐ I have explained the purpose of this referral to the family and have obtained verbal consent for the Northern Health Speech Pathology Department to make contact about this referral.

Name:	Signature:	Date:	Time:

Send completed form to:

Northern Health, Paediatric: Speech Pathology Department **Fax: 03 8405 8616**

**Please attach any relevant assessments or documentation (e.g. Brigance, MoSAIC, hearing test etc.)

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