



SPEECH-LANGUAGE PATHOLOGY GENERAL REFERRAL FORM

Referrals accepted for ages 12+ (as services are for teens, adults, and older adults only).

For all other pediatric referrals ages 11 and under, please visit www.caslpo.com to find a clinician.

Patient's Name: _____ Patient's Phone: _____

Alternate contact: _____ Sex: ____ Date of Birth (D/M/Y): _____

REASON FOR REFERRAL

CLINICAL REFERRALS

- Speech sound/articulation
- Fluency/stuttering
- Language expression/comprehension
- Social communication (ex. Autism)
- Literacy
- Swallowing
- Voice/ habit throat clearing or coughing

- Cognitive-communication difficulty (ex. ADHD, concussion, TBI, "chemo brain", stroke, neurological condition, etc.).

List :

NON-CLINICAL

- Professional/General communication coaching (ex. work-related speaking, social communication anxiety)
- English Accent training/help

OTHER: _____

Comments: _____

Referrer: _____ Professional title: _____

Phone: _____ Other information/stamp:

 Date of referral

 Referrer signature

NOTE: Please inform patient that this is a private practice. Therefore, service fees are out-of-pocket and are not OHIP-covered. SLP service fees may be covered by health benefits plans (employee, student), auto insurance (injured claimants), BlueCross for Veterans, Jordan's Principle (Indigenous patients), or Ontario Autism Program. Expenses may also be considered for income tax purposes.

Thank you for considering Connect Speech for SLP referrals.